COMMISSION OF INQUIRY
INTO THE
NON-MEDICAL USE OF DRUGS

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SUR L'USAGE DES DROGUES
A DES FINS NON MEDICALES

October 24, 1970,
St. John's, Newfoundland.

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BEFORE:

Gerald LeDain, Chairman,

Marie Andree Bertrand, Member,

Ian Campbell, Member,

H. E. Lehmann, M.D., Member,

J. Peter Stein, Member.

EXECUTIVE SECRETARY:

James J. Moore.

SECRETARY TO THE CHAIRMAN:

Vivian Luscombe.

October 24, 1970,
St. John's, Nfld.

---Upon commencing at 9:35 a.m.

THE CHAIRMAN: Ladies and gentlemen, I declare this hearing of the Commission of Inquiry into the Non-Medical Use of Drugs open, and I would like to express our satisfaction of having another opportunity to be here to get your reactions to the interim report, and also some further sense of how you see this phenomena here, and to what extent it has developed or changed since we were last here.

I won't spend a lot of time by way of introduction, but perhaps it would be helpful just to remind you of our terms of reference. We were set up at the end of May, 1969 with a two year mandate to look at all of these psychotropic or mood modifying drugs. There are a considerable number of them, and we have indicated in our interim report in Chapter Two those which we have been given particular attention, and we have been asked to inquire into the effects of these drugs, the extent of the use, patterns of use and the causes of such use, as well as what you might call the social context. In other words, we have tried to put this phenomena into social perspective, and then on the basis of these findings to make recommendations to the Federal Government as to what it can do along or with other levels of Government, to the words of the terms of reference, "To reduce the dimensions of the problems involved in such use". And as we have expressed in the interim report, and we were required to submit an interim report which, as you know, has been

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made public and our terms of reference require us to make a final report, before the end of May, 1971. So we are in the process of working on our final report.

The interim report was conceived of and drafted as a document which might serve as a basis for further discussion by the people of Canada, and we hope that it will assist us in this second phase to focus discussion. We attempted in the report to identify the issues as we saw them in this preliminary stage; to indicate our own findings at that stage, so much of our findings that we felt we could responsibly disclose and stand behind at that stage, and our general approach, our perspective, how we continued to go about our task. In particular, we attempted to indicate the areas in which we would be doing further research, which required more time for consideration. Among one of the most important is treatment, and we said some things about treatment and rehabilitation in the interim report, but we indicated we required more study, including the study of what we have experienced in this country with treatment, and in other countries, before we felt able to make recommendations. We did, of course, make some recommendations in interim character, and particularly recommendations with respect to the law and these were made really in our judgment, recommendations which were justified, regardless of the effects of particular drugs, and regardless whether they were in fact viable alternatives in the way of treatment. In other words, we took the view of the law and we expressed what we felt were things about the law which could not be justified, regard-

less of the effects of the particular drug, and regardless of whether we find there are some other non-coercive or non-penal solutions. Now of course those recommendations, some of them have been a matter of much controversy, and we welcome response or your views on those as well as any other aspects of our approach in the interim report.

The procedure we propose to follow here today is the same as we did last time we were here, and that is, we will hear scheduled submissions and at the end of each there will be an opportunity for questions and discussion, both from the Commission and from others who are present here, and everyone should feel free to give us the benefit of their views. We have placed microphones here for your convenience in the aisles.

So that I should like to call now, and perhaps before doing that, I should introduce the members of the Commission again. On my far right, Dean Ian Campbell of Montreal; and on my immediate right, Dr. Heinz Lehmann of Montreal; I am Gerald LeDain; on my left, Mr. James Moore, Executive Secretary of the Commission, and on Mr. Moore's left, Professor Marie Andree Bertrand of Montreal, and on Professor Bertrand's left is Mr. J. Peter Stein of Vancouver. I should like to call on Dr. David Parsons, President of the Newfoundland Medical Association.

DR. PARSONS: Mr. Chairman, and Commissioners; The Newfoundland Medical Association, which was represented at the first hearings in Newfoundland of the

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1 Royal Commission on the Non-Medical Use of Drugs is again
2 appearing before the Commission for three reasons:-
3 1. To give some of its responses to the Commission's
4 interim report.
5 2. To report certain of the Association's actions since
6 the Commission was last here and to give reasons for these
7 actions.
8 3. To voice concern about the persisting lack of
9 improved medical and other services in connection with
10 problems arising out of the Non-Medical Use of Drugs, and
11 to emphasize the need for improved referral services,
12 special treatment facilities and rehabilitation services.
13 In expressing these opinions, the
14 Association agrees with the view expressed in the interim
15 report of the Commission that the society has a right
16 and responsibility to protect itself against dangerous
17 substances. We are also conscious of the fact that
18 society is very inconsistent in its definitions and
19 responses to various dangers in the environment. The
20 Association accepts the Commission's view that there
21 is no point in having drug laws that damage society
22 more than the drugs from which they are protecting
23 society, and secondly, accept the Commission's view
24 that the emphasis should be on developing and strenth-
25 ening the non-coercive aspects of our social response
26 with a shift from a reliance on suppression to a
27 reliance on the exercise of wise, personal choice. All
28 of the Commission's recommendations concerning the
29 need for research, the need to produce for research
30 standard samples of the cannabis products, the need for

the establishment of a national agency to stimulate research, the need to create a drug education programme based upon research and advice from a central agency and the need for sponsorship of regional drug analysis centres, are all agreed with. The position of the Association regarding possession of psychedelic drugs and cannabis products is contained in a resolution proposed and accepted at the annual meeting of the Newfoundland Medical Association in May, 1970. This resolution recommends that simple possession of psychedelic substances not be punishable by law.

This position was accepted by the Membership on the basis of the opinion that:-

1. A significant number of young people who have easy access to non-medical drugs are not influenced in their choice by legal considerations.

2. Significant numbers of young people can obtain and use these various substances and only a few are arrested. Arrest often occurs by chance or by entrapment or through informants. Because of these factors, the law tends to appear ineffective and is ignored, or appears not to apply equally to all, thereby creating attitudes of disrespect or hostility towards the law and its agents.

3. The social consequences of a criminal record are disproportionate to the acts of the individual and may be more harmful to society and the individual in terms of restraints on the individual in later life than the act of using drugs itself. The fact that an individual may apply for the rescindment of a criminal

record does not really seem to remove the need for continued coercive methods and the continued possibility of unfair application of the law and because the emphasis in such an approach is primarily legal, it is felt to be inadequate.

4. The existence of the law against possession may, through fear, prevent youth from seeking help which they often wish, creates suspicion of the physician and other helping professionals and probably does little to restrain the professional trafficker who deliberately plans his actions to avoid arrest in contrast to the user who often does not, or if he does, does so naively.

5. The view of the Association is that the problems of some members of youth involved in the non-medical use of drugs are complex and beyond the capabilities of the law to deal with them or are so simple, inconsequential and experimental that the full weight of the law does not seem to be required.

The Association has also adopted the resolution recommending that the sale of amphetamine products be discontinued and recommended to its members that they exercise extreme caution in the prescribing of amphetamine derivatives, especially appetite suppressants. The basis for this resolution is that the Association sees only the most limited need for amphetamine products as therapeutic agents and feels that they are frequently prescribed to individuals whose problem is not obesity but depression.

The Association has indicated a willingness

to help and has frequently stated that confidentiality will be maintained when doctors are consulted, so that there has been a slight increase in the tendency to consult physicians about the non-medical use of drugs, but physicians continue to find that our service is limited by the absence of special facilities in the community when these are needed.

Since the Commission was here in Newfoundland in January of this year, the Newfoundland Medical Association has attempted in various ways to acquaint the profession with the medical aspect of various drugs by articles in our Association's news-letter, which goes to all our members; by participation in a seminar held in May in St.John's. At our Annual Convention, we included discussion of the non-medical use of drugs in our Scientific Programme.

The outcome of this was the passing of the resolution mentioned above.

The Department of Health, with the assistance of the Newfoundland Medical Association, sent a questionnaire to the practicing physicians of the Province of Newfoundland. Seventy-two replies were received. The questionnaire asked the doctors of their experience with patients related to certain drugs and their comments on the problem. In summary, the following replies were noted:-

Use of solvent inhalents	-	22 - all under 19 years.
LSD	-	52 cases reported
Marijuana	-	62 cases reported
Amphetamines	-	15 cases reported.

A number of physicians pointed out that the major problem in Newfoundland was still alcoholism.

It was noted that fourteen doctors were requested to speak to various groups on the drug problem.

A variety of comments was noted, ranging from the difficulty to get patients for treatment to the fact that there was no problem in certain areas in the Island with this subject.

This report is appended for your information, Mr. Chairman, and I would like to thank Dr. C. H. Pottle of the Department of Health for supplying our Committee with this information.

I am sure that this reflects a small segment of the whole problem. I am sure it is not statistically valid, but it does give an indication that the patients are going to see the doctors on this problem, and we are aware of them. It indicates that a few of those with a drug problem seek formal medical attention but, again, it suggests that some will go to the doctor knowing that confidentiality will be kept.

On behalf of the Newfoundland Medical Association, I would like to thank you for giving us this opportunity of expressing our views today.

THE CHAIRMAN: Thank you very much, Dr. Parsons.

Dean Campbell?

MR. CAMPBELL: I have a question, Dr. Parsons: could you tell me approximately how many

physicians there are in the province who received the questionnaire? Just roughly.

DR. PARSONS: If I may ask Dr. Pottle.

DR. POTTLE: Approximately 400.

DR. PARSONS: This is what I was suspecting.

DR. LEHMANN: How many?

DR. PARSONS: 400.

MR. CAMPBELL: Do you have any breakdown of the type of cases, or the type of problem presented by the 62 marijuana users?

DR. PARSONS: No sir, other than this in the figures that I give you, there is a small breakdown of age groups, but it certainly isn't complete.

MR. CAMPBELL: With reference to your urging physicians to be careful with the amphetamines, and the recommendation goes beyond that, doesn't it? Is that recommendation on Page 3, where you recommend that the sale of amphetamine products be discontinued.

Presumably, there would be an avenue of sale remaining in those instances where it was clearly indicated under the drug, although it is rarely used by neurologists in cases of narcolepsy.

DR. PARSONS: This is what we were thinking, and it was pointed out recently in the B.M.J. that doctors in the medical profession stop prescribing amphetamines, and in six months it became an amphetamine free area such as the English problem.

MR. CAMPBELL: The English pattern is one of which the amphetamines for intravenous use are

still manufactured, but are only available through hospital pharmacies, and I think the intent would seem to be to really restrict the use to physicians in the large hospitals, teaching hospitals. And as you know, the United Kingdom has moved in this direction with the prescribing of heroin. In other words, there would seem to be, with certain drugs, two classes of physicians: those who are licensed to use these drugs, and other physicians are excluded. Do you see merit in this type of approach?

DR. PARSONS: I think there probably is merit with this. Personally, the number of times amphetamines would need to be used is extremely rare. I think in ten years as an internist I have prescribed amphetamines on one occasion, on any occasion. I don't think they are needed in the general medical use. Now a neurologist as you say with narcolepsy, but there again these are so rare. These are the only times I would think it would be of use. I am quite sure that the majority of physicians, if amphetamines were taken off the market tomorrow, would be of no loss at all from their practice.

MR. CAMPBELL: And making them available would seem reasonable, taking an approach that says, "all right, a neurologist may need this drug, but only the neurologist may prescribe it."

DR. PARSONS: I don't think anybody would argue with this approach.

THE CHAIRMAN: Dr. Lehmann?

DR. LEHMANN: I wonder, Dr. Parsons,

whether people wouldn't argue with this approach, because so far there are no drugs which have a label attached that only certain specialties, only the dermatologist may use this, or only the internist or the surgeon, or only the psychiatrist. I could foresee considerable protest from the medical profession at large if certain drugs, and this has been repeatedly proposed, certain drugs would require a special examination by the doctor before, for instance, and have drugs, which are difficult to prescribe, but the medical profession so far, and the thing --- there could be considerable trouble if you could say only a neurologist could prescribe it. Besides, a psychiatrist may want to prescribe it. And at a recent meeting in New York, a representative on depression, Dr. Cole, one of the foremost authorities in psychopharmacology, he said there may be and there are certain depressions and indications for amphetamines. It is true, probably only a psychiatrist in many cases could make the proper indication, but it still would be required, besides there is considerable indication for it, almost, a specific one in hyperactive children wherein the general practitioner might be required to prescribe it for anti-convulsions for quite a long time. So I am just wondering about your very definite resolution to stop the sale of amphetamines. Has that been acted on or is that just a recommendation?

DR. PARSONS: It is a recommendation, and we have forwarded this recommendation to the Department of Health and the Newfoundland Pharmaceutical Association, and we have informed our members regarding

the prescribing. Now how far it will go from here is up to continued discussion on this matter.

DR. LEHMANN: The warning certainly is very indicated. In Scandinavia amphetamines are completely outlawed and they still have an amphetamine problem because it comes in through illegal channels.

DR. PARSONS: Isn't heroin not allowed in Canada?

DR. LEHMANN: Same, it also comes in. So that would not be a guaranteed proof that we wouldn't, or guarantee that we wouldn't have any more amphetamine problem. In fact, much of the amphetamine that is being used for speed is not is being prescribed.

DR. PARSONS: I think some of our members were mainly thinking of the certain problem with amphetamine, not only with the alter group, anti-depressant, and this is one of the reasons we were being, if you want to call it, over-dogmatic.

DR. LEHMANN: The over prescribing for obesity.

DR. PARSONS: And keeping it on. One other point that you brought up, you say that there is no group that can prescribe one drug. I think it is well accepted that when a new drug comes on the market, a certain group are allowed to prescribe this for research purposes over a period of time, and I think this is generally accepted by the profession, and I think it may serve as a drug --- at least I am speaking as private opinion now, and I think understanding the problem, people would accept --- at least in our practice

I would think people would accept this as being quite acceptable.

DR. LEHMANN: Just as it is now being licensed only to researchers, so certain drugs that are particularly hazardous proposed might be restricted to certain physicians.

DR. PARSONS: Yes, that is right.

MR. CAMPBELL: You mention the opiates in this list, Dr. Parsons. Does this imply there is virtually no problem with opiate addiction?

DR. PARSONS: This is true in Newfoundland. I think in the list there was mentioned one person who was a transient passing through, but it is usually transients up to now so far as I know, and there has been really very little problem with opiates in Newfoundland.

THE CHAIRMAN: Doctor, I would like to return to this question of the amphetamines,we have certainly had other suggestions, and I can't recall precisely where, but I have a distinct recollection there were other suggestions of the complete prohibition of amphetamines, and also I understand that in some other areas in Canada, physicians have by agreement ---

DR. LEHMANN: The Yukon.

THE CHAIRMAN: Actually prohibited, or is it an agreement between the physicians?

DR. LEHMANN: It is an agreement and I think they have agreed not to sell it.

THE CHAIRMAN: I think it was at a meeting in Niagara and I was told that their physicians

and pharmacists have been cooperating to reduce the availability of amphetamines. We know they have been completely prohibited in Sweden. I think that we have to sift this possible --- this recommendation, possible solution. What would your own opinion be of general medical opinion in Canada concerning the therapeutic necessity of amphetamines? On whether doctors should get along without them or not?

DR. PARSONS: Dr. Lehmann mentioned two groups, narcolepsy and hyperactive children. I'm afraid I'm not in a position to say you could do without them absolutely in these cases.

THE CHAIRMAN: Well, balancing the cost and benefits, are those in your judgment, do those uses justify the problems as a result of the abundant supply in amphetamines?

DR. PARSONS: Oh no. I think that probably --- it is unfortunate that even if you did abolish them altogether, there would still be some coming in. I am recognizing this. The use of them, I think, is on such a small scale and abolishing them altogether would probably benefit, if you want to say, the majority or the few.

THE CHAIRMAN: In effect you support, or the Association of Newfoundland supports, this position?

DR. PARSONS: Yes.

THE CHAIRMAN: Yes. Because I wanted to make sure I understood it. You speak about recommending the sale of amphetamine products be discontinued, and then you say the members exercise extreme caution of

prescribing amphetamine derivatives, and I am wondering just whether this is an interim measure, the caution.

DR. PARSONS: The caution was an interim measure. If I may read out the actual resolution:-

"Be it resolved that the members of this Association will exercise extreme caution in the prescribing of amphetamine and other anti-suppresants and be it resolved that this Association recommend to the Minister of Health and through him at the appropriate time, to the Federal Minister that the prescribing and the sale of amphetamines be discontinued."

So I think this explains our views.

DR. LEHMANN: Dr. Parsons, why was this last recommendation made? Because as you mentioned in one region in England there was a report that after they discontinued the use of amphetamines, they disappeared from the illicit use, almost disappeared, is that what prompted you?

DR. PARSONS: I think this appeared in the C.M.H.A. brief, reference to it quite recently.

DR. LEHMANN: So this resolution was really made before?

DR. PARSONS: Oh yes.

DR. LEHMANN: On what basis? There is one that you mentioned, number one, really comparatively few would be losing out on it, but that wouldn't be enough really because there are a lot of drugs on the

1 market where very few really benefited from them. But
2 the reason would be, you assumed, or the Association
3 assumes that by prohibiting the sale, it would somehow
4 help the problem of illicit amphetamine use; is that
5 it?
6 DR. PARSONS: This and the fact that
7 we felt the majority of times amphetamines were
8 prescribed was not necessary. In other words, it was
9 a very questionable drug that has very questionable
10 use, except in these very few specific cases, and that
11 the majority of times that it was prescribed, it was
12 not really necessary.
13 THE CHAIRMAN: There is really three
14 factors: one, that it helps very few people and
15 therefore, few would suffer if it was not longer to
16 be sold; secondly, the medical profession is prescribing
17 it loosely?
18 DR. PARSONS: Yes.
19 DR. LEHMANN: And therefore sometimes
20 producing eogentrogentic disorders, dependency and so
21 on. And thirdly, the illicit speed use may be reduced
22 by it.
23 DR. PARSONS: That's right.
24 MR. CAMPBELL: Still with the amphetamines,
25 Dr. Parsons, the fifteen cases, have you any idea if
26 these were mainly problems around the oral use of
27 amphetamines or did it involve intravenous use?
28 DR. PARSONS: Here again, we don't have
29 that definite use. This was a written questionnaire
30 and the answers were in some cases very vague, "Yes, I

have" and I think it was noted one or two of these were in the older age group, starting with taking them as an appetite suppressant and keeping them on.

MR. CAMPBELL: What would you say the practice here in St. John's --- are your colleagues as far as you know running into problems with amphetamine use?

DR. PARSONS: I think perhaps Dr. Falconer or Dr. Pottle could give you more information on this, Dr. Boddie will be speaking later.

THE PUBLIC: Chairman, sir, may I make an opinion? My name is Dr. Bhattacharia. I am a psychiatrist in the mental hospital, and I will also be presenting the Drug Commission with a brief from the Psychiatric Association of Newfoundland,

I would like to speak to these drugs. Some of the criticisms --- to clarify a point, those psychiatrists who authorized in Britain, they were all at a consultant level and these were authorized physicians or psychiatrists who were only dealing with known drug addicts. That is to say, he could give dexedrine or opiates to a known drug addict, but he did not bar other doctors or any other specialists that they could not use these drugs if they thought it was necessary for the patient for treatment. The other thing is that amphetamine usage in Britain, that when it was withheld, that particular area was amphetamine free. I think you realize, and I have a good deal of experience on that if a particular province is deprived of a drug, they obviously go to

1 another province or they go down to London, or they
2 go down to Birmingham. And if this happened to be
3 between way. Just so one area is cleared up, it is no
4 indication that really they did not have an amphetamine
5 problem.
6 And to talk about the withdrawal of the
7 drug, I think is one of the --- in my personal opinions
8 a nonsensical thing to say. LSD was withdrawn in
9 Britain, and has been withdrawn in Canada, North
10 America. We are seeing more and more LSD takers.
11 When it was withdrawn in Britain, and I made some fuss
12 about it, I wrote letters and things, and wrote in
13 medical journals and we imported this from Poland, and
14 it is still being used as a medical drug, In North
15 American it has been withdrawn and if anything, LSD
16 taking is on the increase. So this kind of statistics
17 we have I think are valueless until and unless we take
18 the whole ontological problems, all kinds of things,
19 and be able to say that we withdraw amphetamine, and I
20 don't think amphetamines have such a minor application.
21 The World Organization with Dr. Stengle, people like
22 that, all met, and they came with the view that the
23 psychedelic, psychopathic personalities, the people
24 who take amphetamines, do benefit from amphetamines,
25 so it is unfair to say it has such a limited use. You
26 have possibly not seen the group of people that may
27 benefit from amphetamine itself, and epilepsy which is
28 not so uncommon in children, benefit from amphe-
29 tamine as mentioned. Only epileptics are often
30 given amphetamines and there are all types of varieties

of illnesses that I can go on saying, that amphetamine might be better. Again, the cardiologist might have to use it when you have hypertension, persistent hypertension. Give a little methadrine and the blood pressure rises. I have seen four cases like that in Britain where they were brought to me, and as I say, these were methadrine addicts, and when they were withdrawn they all became hypertensive and since then, every cardiologist at the hospital investigated, and if you gave them methadrine, their blood pressure was raised and they were better.

Thank you, sir.

THE CHAIRMAN: Thank you.

Dr. Parsons, would you care to comment on that list of uses?

DR. PARSONS: As I said, I am sure there are, but I still believe the general use of these from the general medical practice still would benefit if these were withdrawn. It may be suggested that specialists such as Dr. Bhattacharia, psychiatrists, certain groups of doctors, may be able to use these at times to benefit, but I think from the general medical practice, it would be a benefit if these were withdrawn, and here again, I am giving a private opinion, personal opinion.

THE CHAIRMAN: Professor Bertrand?

MISS BERTRAND: Could we go back to Page 2 of your brief please? The first paragraph speaks of the possession of psychedelic drugs, cannabis products, and further you say,

"This recommendation recommends that

simple possession of psychedelic drugs should not be punishable by law."

Would you kindly tell me what you include at this point in the psychedelic substances?

DR. PARSONS: I think we left this very broad, mainly because new products are always being produced and we didn't pinpoint it to any particular drugs.

MISS BERTRAND: Do I understand your definition of psychedelic is mood modifying? What is your definition of psychedelic?

DR. PARSONS: I think it would be those drugs that have an adverse-mood changing affect would be the best broad definition.

THE CHAIRMAN: In other words, would you use it synonymously with psychotropic?

DR. PARSONS: I think so, yes,

THE CHAIRMAN: In other words, the drugs covered by our Inquiry, we have to look at psychotropic drugs, mood modifying.

DR. PARSONS: Yes; that is right, yes.

THE CHAIRMAN: Dr. Lehmann?

DR. LEHMANN: I would like to clarify a point here that isn't clear for Commissioner Campbell and myself. Following your remark, Doctor, or about your comments on Britain, what are the regulations there? I understood from what you said that physicians in Britain may prescribe amphetamines, while in Sweden they may not. In Britain they may prescribe amphetamines, but from what you said, I understood only

1 the certain specially licensed physicians may prescribe
2 amphetamines for known addicts, while every physician
3 may prescribe amphetamines for clinical indications
4 to non addicts. Is that what you said?
5 DR. BHATTACHARIA: Yes. What I mean,
6 that if there is drug addiction, it is only the
7 authorized doctors and continue to give them the
8 drugs should they help, but it does not bar other
9 doctors to prescribe other drugs they choose. The
10 only thing they made on LSD on a special usage, a
11 consultant psychiatrist has to ask for the requisition
12 to obtain LSD for that hospital, and they should not
13 be able to practice that in the private practice.
14 DR. LEHMANN: That is LSD and heroin
15 too, isn't it?
16 DR. BHATTACHARIA: Yes.
17 DR. LEHMANN: Heroin and LSD then can
18 only be prescribed in special clinics, but amphetamines
19 may be prescribed by any physician except if the
20 physician knows it is a known addict, and in that
21 case you may not prescribe it to him?
22 DR. BHATTACHARIA: He is only treating
23 the drug addiction, not the individual. If the person
24 is a drug addict and if he has to be treated by
25 anybody, then these authorized physicians who treat
26 them by giving them drugs, all by trying to withdraw
27 the drugs is the treatment of addiction is the point,
28 not the drug.
29 DR. LEHMANN: Thank you.
30 MR. STEIN: Could we go back again to

that Page 2. Would you include amphetamines in your definition of mood modifying drugs?

THE CHAIRMAN: Excuse me, Dr. Parsons. There is still some question about the scope of the words "psychedelic", the intended scope of the word "psychedelic drugs and cannabis products". Was that the language actually used in the resolution of the Association?

MR. PARSONS: If I could read out the resolution, and this refers back to the conference and,

> "Be it resolved that this Association agrees with and supports the motion passed unanimously at Vanier Conference on the Family and Youth held recently to the effect that the simple possession of psychedelic drugs and cannabis products and any further similar products not be punishable by law."

I believe the meaning was that the Association at that time did not feel that all of these drugs had been known, and that new ones were becoming available, and that we wanted, as I said, to leave it as broad as possible to include those drugs that are commonly understood to be psychotropic drugs.

MR. STEIN: The question perhaps would be; were this recommendation to be implemented, and were your other recommendation to be implemented, namely, the one for all practical purposes, banning the use of amphetamines, would there not be some conflict here, or what would you do with those persons who continued to be users of

amphetamines? Would you want to ---

DR. PARSONS: I see there is a problem with the law. Well actually, I suppose if possession of a substance that is illegal would be punishable by law , and therefore you are contravening one and the other, I see the argument there. I am afraid we didn't look that far ahead when we were thinking of our resolutions,

DR. LEHMANN: The same would apply to heroin and LSD.

MISS BERTRAND: Yes.

DR. PARSONS: Yes, I would presume this would be so.

THE CHAIRMAN: But in your recommendation concerning amphetamines as I understand, you recommend that the sale and prescription and distribution be prohibited?

DR. PARSONS: Yes.

THE CHAIRMAN: So it doesn't necessarily evolve that you would require punishment for possession, does it?

DR. PARSONS: No. It was just in the hope by taking it off the market, it would reduce a certain amount of the problem, and was mentioned before, that these substances certainly do come in on the market regardless of what you do. Prohibition in the States showed this as far as alcohol was concerned,

THE CHAIRMAN: I was wondering, and I understand now your Association supported the recommendation of the Vanier Conference so that in effect one would have to go back to I guess the Vanier Conference discussion

and see if there is any record of it to ascertain the intended scope of the word "psychedelic".

Is it your sense or your Association's feeling on this that in making this recommendation about simple possession, they are not really making distinctions among the drugs. Do you think it is their sense they are dealing with all the drugs, or only those which might strictly be called psychedelic, such as the hallucinogens, LSD, and others? I think that is what we are concerned about. We don't want to contribute to this recommendation more than we ought to. Do you know what I mean? For example, do you think your Association is contemplating the possession of heroin, for example, the opiate narcotics?

DR. PARSONS: I don't think they are going this far, but if I could ask Dr. Boddie who is Chairman of the Committee, who drew up these recommendations, if he could say a word at this time

THE CHAIRMAN: Dr. Boddie?

DR. BODDIE: Thank you, Mr. Chairman. Both the proposer and the seconder of this resolution are present, and will speak with you shortly.

The intention of the resolution as I understand it, is that the application of legal measures against an individual in possession of a psychedelic substance was not likely to be effective in terms of control, rehabilitation, etc. The scope of products referred to is, again, as I understand our resolution, very broad. It includes the cannabis products, the hallucinogens. The committee gave no special considera-

tion to heroin. I think we were influenced perhaps by our local situation, and this is perhaps something Dr. Witty would have to examine again. But speaking at this point presently, one has to be consistent on one's point of view, and that is that legal action alone, taking legal action against possession of a drug is not a way to assist them, and one would have to include all mood altering drugs.

THE CHAIRMAN: Are you --- do you share that view, Dr. Parsons?

DR. PARSONS: At the convention last spring, this was the view before it, and I think this was the view accepted by the Association.

THE CHAIRMAN: Thank you.

Are there any other questions or observations?

Dr. Lehmann?

DR. LEHMANN: Well, that would mean that such substances as LSD and also STP and any new substances in the psychedelic area should not be punishable by law?

DR. PARSONS: This is correct.

DR. LEHMANN: And again you did not consider heroin? You feel this is not necessarily included here?

DR. PARSONS: No. As Dr. Boddie pointed out and as I mentioned before, hard drugs are very rare here to the best of my knowledge. It is most unusual, and these are usually imports from the mainland or elsewhere; people passing through here for

1 some other reason. And I think this is what we were
2 considering when this resolution was passed, and I
3 don't think this came up in our thinking at all.
4 DR. LEHMANN: But it is a recommendation
5 to be made to the Federal Government for Federal law?
6 DR. PARSONS: I understand that, but
7 here again, this will go back to the committee, but
8 it was not to include, I understand, those so called
9 "hard drugs," which I realize is a bad expression to use,
10 but ---
11 MISS BERTRAND: On Page 4 of your brief
12 you report on the replies to your questionnaire, and
13 you told us previously that you couldn't give us
14 details on the problems, say, that were brought to
15 the attention of the physician. But would you know
16 if all the cases reported by the physicians were dealt
17 or were known through the youngsters themselves, or
18 through their parents? In other words, was it the
19 parents who came to the physicians' offices or was
20 it the youngsters?
21 DR. PARSONS: No. I believe these were
22 mainly cases that the physicians had actually seen.
23 There was a question on this questionnaire about
24 whether parents have brought them in, and the
25 replies at least indicated that this was in very few
26 cases. But I don't think that the questionnaire
27 probably has sufficient information on this matter.
28 THE CHAIRMAN: Do you have any facts
29 or details on the cases themselves, Dr. Parsons?
30 DR. PARSONS: No sir, all of the

1 information is in that which is included ---

2 THE CHAIRMAN: How can we get the facts

3 of these cases, what the adverse reactions were?

4 DR. PARSONS: I doubt whether we could.

5 As you can see, this was a questionnaire sent out with

6 no name, so there was no way of getting back to the

7 physician unless Dr. Pottle has some information.

8 DR. LEHMANN: I am just wondering whether

9 there were adverse reactions.

10 THE CHAIRMAN: What were the 62 cases on

11 marijuana?

12 DR. PARSONS: I think this was just:

13 "Have you seen any in your practice?" The questionnaire

14 was sent out to try and find out approximately if there

15 was any drug problem here. If doctors were seeing

16 cases and the copy of the questionnaire is there, and

17 I think these were replies to: "How many have you seen

18 in your practice?"

19 THE CHAIRMAN: I understand Dr. Boddie is

20 going to deal with the question; is that right?

21 DR. BODDIE: Sir, I have some personal

22 observations of my own practice to present to the

23 Commission.

24 THE CHAIRMAN: Fine.

25 DR. LEHMANN: May I clarify this: it says

26 here, the questionnaire asks doctors of their experience

27 with patients relating to certain drugs, and then so

28 many cases. Is it conceivable that a doctor then who

29 knew of six or eight youngsters who smoked marijuana,

30 but were treated for other things, then would put them

1 down because in his opinion they are problems because
2 they smoke ---
3 DR. PARSONS: This is a possibility, and
4 there is no way of knowing it.
5 THE CHAIRMAN: Are we going to hear
6 what the views were on the need for special treatment
7 facilities?
8 DR. PARSONS: I think Dr. Boddie will
9 probably give us more information on this.
10 THE CHAIRMAN: Are there any other
11 questions or observations?
12 FATHER HOLLAND: Father Holland, High
13 School Councillor and I don't understand the point
14 about the doctors, the medical business goes on. As
15 I read the Inquiry Into the Non-Medical Use of Drugs
16 and the questions directed and some of the observations
17 or recommendations made were on precisely the medical
18 use of drugs. I am confused, Mr. Chairman.
19 THE CHAIRMAN: Yes. That is a fair
20 observation. Well, we had to determine what meaning
21 we were to give to the expression "non-medical use"
22 in order to determine the limits of our Inquiry. And
23 we decided, and the definition we gave was that non-
24 medical use is use which is not justified though for
25 generally accepted medical reasons, and it is not just
26 a question of prescription or no prescription. The
27 question is whether the use is justified for
28 generally accepted medical reasons, therefore, we
29 have to try to draw the line, difficult as it is,
30 between medical and non-medical use. So prescription

1 prescribing practices we consider relevant to our
2 Inquiry. Doctors use reasonable medical requirements
3 for these drugs relevant to our Inquiry. And generally
4 speaking, since the medical source and use of these
5 drugs can be diverted to some extent to non-medical use,
6 it is also I think relevant to our Inquiry to consider
7 as for example, whether amphetamines have still a
8 justifiable medical use. Now we may be going quite
9 far afield, and someone might well say to us, "Look,
10 you weren't asked to pass on justifiable medical use of
11 amphetamines", and we could say, "Well, it has been
12 suggested to us that it should be abolished, eliminated
13 as a means of coping with the non-medical use of
14 amphetamines as a measure or means." So these are the
15 relationships, but I quite agree with you, we experience
16 some of your own concern over trying to stay within our
17 mandate.
18 DR. LEHMANN: Well, it goes as far as to,
19 and as Dr. Parsons pointed out, and many other physicians
20 of the Medical Associations have pointed out,that
21 quite often physicians make non-medical use of drugs
22 when prescribing it when not necessary. According to
23 our definition, this would be a non-medical use of drugs
24 by physicians prescribing it because it is not accepted
25 or it is not in accordance with good medical practice.
26 MR. CAMPBELL: There is also both the
27 Canadian and International precedent for instance, with
28 respect to heroin. Heroin isn't a recognized drug
29 with a physician in Canada, and is not permitted. Well,
30 is unable at this time to prescribe heroin, much the

same as the Swedish stand on heroin.

THE CHAIRMAN: But it is very helpful to have that question asked. We like to be reminded of that.

Are there any other questions or comments?

You will be remaining here, will you, Dr. Parsons?

DR. PARSONS: Unfortunately, I have other things, but Dr. Boddie will be here and I believe Dr. Pottle will be here. Dr. Pottle is very familiar with our brief and so I am sure he will be able to answer any questions and may clear up some of these problems when he gives his own personal views.

THE CHAIRMAN: One, of course, general question which we continue to be interested in which you made allusion to in your opening remarks, is the whole thing of treatment facilities.

DR. PARSONS: Dr. Boddie is certainly more familiar with this and we hope he will be able to fill in there.

THE CHAIRMAN: Thank you very much for your help again, Dr. Parsons.

DR. PARSONS: Thank you.

THE CHAIRMAN: Dr. Boddie?

DR. PARSONS: Dr. Boddie, as you undoubtedly know, is Chairman of the Sub-Committee of the Medical Association, Sub-Committee on the Non-Medical Use of Drugs of the Association.

DR. BODDIE: Mr. Chairman, Commissioners,

1 this is an individual submission. I apologize for not
2 having presented the Commission with a prepared brief,
3 but it was not possible to do so.
4 My opinions which I express are
5 influenced by the nature of the work which I do,
6 practicing as a psychiatrist primarily with adolescents
7 and families, and in my connection with the Student
8 Health Service at Memorial University, and as Chairman
9 of the Sub-Committee on the Non-Medical Use of Drugs
10 of the Medical Association. I wish to thank you for
11 the opportunity to appear before you again. My purpose
12 in doing so is, first of all, to strongly support the
13 philosophical position of the interim report of the
14 Commission. And this position, as I understand it, is
15 that individuals in society should be encouraged on
16 making decisions on the self administration of the
17 many chemicals available to them and base these decisions
18 upon wise, personal choice, rather than through fear
19 and coercion.
20 My second objective is to support the
21 views of the Commission which arise naturally from such
22 a philosophy; that it is necessary that the Federal
23 Government rationalize the drug problems and sponsor
24 research, provide information and leadership to drug
25 education programmes, and provide initiative and
26 support for community services for youth involved in
27 the non-medical use of drugs. And I wish to further
28 report to the Commission the experience with youth in
29 the non-medical use of drugs in order to provide a
30 demonstration in support of the philosophy of the

1 Commission and to give me an opportunity to raise some
2 problems.
3 Now, commenting upon these objectives
4 I wish to refer briefly to the question of rational-
5 izing the laws with respect to drugs. In this matter
6 my views coincide with those already expressed by the
7 President of the Newfoundland Medical Association with
8 reference to both resolutions. I support the arguments
9 advanced in favour of this position by the Medical
10 Association, but in addition to this I, personally,
11 particularly am concerned about the continuation of
12 laws related to simple possession, because I believe I
13 am correct when I said that there are some individuals
14 in this community that cooperate secretly in providing
15 information about their peers possibly for gain. My
16 knowledge of this information leads me to view them
17 as alienated, anti-social persons and it repels me
18 that their clandestine work gives them discretionary
19 powers.
20 I contend a continuation of a law against
21 such tactics, should be discontinued, and reliance on
22 such methods is wrong.
23 I would like to present briefly some
24 clinical experience. In reporting this experience,
25 I wish to point out that prior to January of 1970,
26 though I have been aware for about two years that
27 there are mood altering drugs available in the community,
28 very few young people had consulted myself or any
29 colleague about the matter. The few young people who
30 were seen were usually juveniles involved with solvent

1 inhalation who were brought to the physician, often
2 against their will by parents or agencies.
3 In reviewing my experience for the period
4 of January to April, 1970, I find that I have seen 50
5 users of various non-prescribed products, not including
6 alcohol. It is my impression, however, that I have
7 seen far more people of all ages who have abused
8 tranquillizers and sedatives to a dangerous degree,
9 including some serious suicidal attempts. This
10 experience or the experience to which I refer does
11 not include alcohol which is quite extensively used
12 by youth.
13 Of the 50 people seen, 7 were using
14 solvents and 5 of these were very disturbed children
15 between the ages of 10 and 14, and one was a very
16 disturbed 17 year old, and one at one time experimented
17 at the age of 16. These children can be illustrated
18 by one boy who used to sniff a tube of glue on the
19 way home from school to his grossly psychotic mother,
20 and so this was the only way he could face her.
21 Of the remaining 43, all but one were
22 young. With the exception, a highly trained person
23 of 50 years old was using a variety of drugs for misuse
24 and the youngest of this group over a period of time
25 was 15 years of age. The other 42 had all used LSD
26 or similar drugs on one or more occasions, and all had
27 tried cannabis on one or more occasions, and only 2
28 were regular users of amphetamines. The 2 further
29 individuals had used amphetamines on one occasion, one
30 orally and one intraveneously.

Looking at these individuals in an impressionistic way I have not been able to determine any other single common factor except that of drug use, and even that common factor, that is, the common factor of drug use, differ considerably in frequency, amount, attitude and continuation. And generally, individuals who I saw have better than average intelligence. None tended to act out any social digressive manner. The group was as heterogeneous as any group of young people of high school and university age. And location was varied, including individuals from abroad and from points ranging from Sudan to St. John's. It included very successful and unsuccessful students. Included in the group were 5 individuals who I would consider to be schizophrenic and this is more than one would expect in a population so large and probably a distribution in an age group or in some practices at home. Reasons vary. Sometimes because of one kind of experiment which have been unpleasant and they were afraid they had damaged themselves. This group tended to be somewhat depressed and had other --- more than the normal adolescent problems.

Two other individuals experienced the effect in the form of hallucinations and were afraid they were becoming mentally ill. One girl was fearful of chromosomal damage and the effects on her future children. Three were seen because of presumed bad trips which I believe to have been relatively minor in the extent based on the prescription I had given them. Twenty percent had other problems in their lives

1 when the question of drugs appeared. Subsequently, types
2 of problems encountered were not too different from
3 those encountered in adolescence a few years ago. It
4 is my impression that for these adolescents the problems
5 are the same, and what the adolescent does is different.
6 On the other hand let us go to 20
7 adolescents and their problems today, with similar
8 problems and not using drugs. This might suggest that
9 the adjustment problems of circumstances and surroundings
10 coupled with availability and lack of knowledge or
11 pseudo knowledge about drugs could result in the
12 therapeutic trial of the psychedelic drug, which could
13 be tried again and used again as a group association.
14 The motivation for the use of drugs
15 seemed to vary as widely as anything else in the group
16 including experimentation, enjoyment, search for high
17 level of experience, desire to understand the friend's
18 experience and a way out of intolerant problems and
19 treatment among friends who it would appear might
20 understand them and be able to communicate.
21 I have not included this through
22 oversight, but it did come up in connection with the
23 question posed to Dr. Parsons with regard to cannabis
24 products. As a rule, the users of marijuana did not
25 tend to seek help because of the use of marijuana at
26 all. They came for other reasons, and this came up
27 coincidentally. The users of amphetamine products
28 tended not to seek help. I am aware of individuals who
29 are using amphetamines that are not motivated to seek
30 help. The group who came specifically because of the

1 drug where there is over use of the hallucinogens such
2 as LSD.
3 The individuals seen first in 1970
4 were young people, with one exception, a 50 year
5 old individual. It is my view that the change
6 occurable related to two events. The public demonstra-
7 tion at the first hearings of the Commission by the
8 Commission and those who appeared before it that
9 attitudes could be rational, and that help
10 of that consequence is available.
11 A review of the situation since April
12 indicates similar trends in increasing numbers. There
13 seem, however, to be some slightly different trends
14 emerging. I am not entirely clear about these because
15 time has not permitted me to give any proper examination
16 and these are subjective impressions again.
17 A minority of younger and I believe
18 more disturbed youth have been seen, the youngest
19 being 12-- and with considerable experience with LSD
20 for a one year period prior to being seen. On the
21 other hand, there have been more requests for specific
22 help to get off LSD. In spite of the varied age and
23 motivation and frequency and duration of an experience
24 with LSD, nearly all of these described a common
25 difficulty. As a result of the social aspects of the
26 drug experience, they found themselves alienated to
27 a great degree from their non-drug using appearance.
28 And after giving up drugs, they found themselves
29 alienated from their drug using peers with whom they
30 often continued to associate.

[illegible] are a [illegible] use of [illegible] hallucinogens such as LSD.

[illegible] first in 1970 were young people, [illegible] a 50 year old [illegible] the change [illegible] public [illegible] [illegible] tions appear before it that [illegible]

[illegible] in [illegible] number. There [illegible] different trends [illegible] also [illegible] these because [illegible] proper examination [illegible]

[illegible] be [illegible] you [illegible] [illegible] in USD [illegible] an. O this [illegible] are [illegible] for people [illegible] and [illegible] if an experience [illegible] a common [illegible] aspects of the [illegible] [illegible] us [illegible]

I am aware of considerable pressure from these individuals for alternatives to cope with this problem. Pressure by school administration and family or a-ditional factors compounding the problems and the attitude of defeat and hopelessness. All but a small number of these young people sought help voluntarily, and through conventional channels. The exceptions were adolescents brought by their parents and in these instances it was my view that family problems preceded the drug problem and in most instances the adolescent rejected the whole idea of help, and he found the parents the same way, as almost anything else about the parents was rejected.

These experiences I wish to mention and some conclusions which may be relevant even though speculative: if services are available to youth which can be utilized on a voluntary basis and where the emphasis is on the person and not upon the behaviour of the individual and where more confidentiality is maintained, it will be used. Two, that the present laws related to simple possession of drugs are a hindrance to such an approach. Three, that our present laws related to the treatment of minors are doing more harm than good. Four, many professional groups need more education if they are to help youth with these problems. Five, and this is to me an important point which arose out of experiences with community groups and youth in endeavours to establish a drop in centre. I don't really understand the problem, and that is perhaps

the main thing I want to state, because I think we need some help. Youth institutions, community groups and professionals need help in devising ways of cooperating on more than a haphazard individual basis.

And this may be a problem of trust.

In order to promote this trust, we seem to need new approaches and the smaller community may need to be able to draw on the experience of larger areas with more resources and more research facilities.

I wish to thank the Commission again for the privilege of appearing and it is sincerely hoped the work of the Commission, which is a serious endeavour and communities, including youth, can cooperate or under legislation of the Government can reflect and recognize the degree of participation which can occur when opportunity is presented.

I wish to point out that I was providing specific information, but by treatment facilities as such, and if I can I will give my views,although I don't think they were very original.

THE CHAIRMAN: Thank you, Dr. Boddie. I was particularly interested in what you were saying about the psychological characteristics which you have observed in your own practice, your contact with drug users. Now we made a statement in the interim report which has been the subject of some criticism, and we are trying to evaluate that criticism and get the benefit of all the advice of officials and others all

across Canada on it.

The statement is on Page 222 of our report at the bottom of the page, and there is a paragraph under,and we attempt to sum up causes, and of course we do stress that this is an interim sort of summary, our initial impressions, but we do say this:-

> "There has been some tendency to think of the motives for drug use as pathological or as reflecting a pathological psychological condition. This is shown by the tendency to turn to the physician,and particularly to psychiatrists, for help in understanding the drug phenomenon. There is no doubt that some drug users are to some degree mentally ill. However, we are convinced that the vast majority fall within the normal range of psychological functioning."

Of course this is our perception of what we must regard as normal and abnormal in our society today, but that statement we have to, as I say, and we have received some questioning with respect to criticism, and I would be interested in your views and in the light of what you have said this morning, and your own observations.

DR. BODDIE: My first comment would be that the fact that these individuals came to me does not necessarily indicate the presence of a major pathology at any rate. They can come to me if they wish to ask questions and if they hope to get answers. The pathology I did not feel was any different in this group

than a group of non-drug users who I also saw in the same major --- but I would agree with the idea expressed by the Commission that there are many individuals who may, for one reason or another, use drugs, who are not necessarily abnormal to any serious extent. Now this is not to say of course they will not consult professionals and other people on other matters.

THE CHAIRMAN: Dean Campbell?

MR. CAMPBELL: Dr. Boddie, if you could tell us about the more informal services that are available to young people in Newfoundland, are there drop in centres? Are there crisis intervention centres apart from the hospital?

DR. BODDIE: No, there are no informal facilities available at this point. However, a service club in the community has made an attempt, or is making an attempt to establish a drop in centre and I have referred to some of the problems in getting this thing going. I have been in contact with the group for the last month or so and it is their intention to proceed. I also believe another youth organization is becoming interested on a somewhat broader aspect of youth, but would also have some reference to youth that were using drugs non-medically. But there is no existing informal facility at this time.

MR. CAMPBELL: What about among young people themselves? Has there been any apparent wish as far as you know to act by themselves, quite apart from service groups. Have they tried to establish this facility?

DR. BODDIE: Yes.

MR. CAMPBELL: Why has it not gone forward?

DR. BODDIE: I feel probably because of lack of resources. There is no way of supporting such a thing. Probably also lack of experience. I neglected to mention by the way, that on campus at the present time, and I haven't got too much information about this, because I was unable to be present at meetings, but I hope to do so soon; that there is a move to set up some telephone service, probably a drop in type of arrangement and this will be youth organized as I understand, with back up professionals if required.

MR. CAMPBELL: Have the existing institutions, for instance, the hospital made any move to involve young lay people in their operations as they affect drug users, or young people, and particularly I am thinking of a hospital recently where attached street workers were taken in to the hospital for periods of a couple of months, and these people, rather than physicians, did the admission. They managed the patient rather than the physicians, but is there any movement in that general direction?

DR. BODDIE: I don't think we have passed beyond the point of solving --- and really perhaps I am somewhat impatient in this. The elementary problem is the treatment of minors. There has been no move in this direction at all.

MR. CAMPBELL: In your view, is there a place for the young lay person to play this type of role in the institutions, such as the hospital?

1 DR. BODDIE: Yes. I feel there is.
2 Quite definitely so, because one of the problems in the
3 young person coming to a hospital, although I am not
4 implying by this that the hospital is aiding much, but
5 suspicion, fear of rejection, and fear sometimes is
6 intimate in the lack of knowledge on the part of doctors
7 and nurses in the matter of dealing with the problem.
8 There seems to be more acceptance in hospitals among
9 some doctors approaching broader problems in an elected
10 way rather than on an emergency basis. But I do feel
11 young people could be involved. They certainly are
12 involved in other ways in hospitals as volunteers, and
13 do a very effective job. I feel, and I adhere to the
14 idea, that youth participation is essential if we are
15 to approach the position that the Commission has
16 adopted, that of choice.
17 THE CHAIRMAN: Speaking of your 50 cases
18 in January to February, I didn't or wasn't quite sure
19 that I understood the reasons the amphetamine users
20 or users of amphetamines presented themselves. I
21 understood you to say the amphetamine users did not
22 seek help; is that correct?
23 DR. BODDIE: That is what I meant.
24 THE CHAIRMAN: Did you actually see
25 them? But what did you mean, they didn't see ---
26 DR. BODDIE: I am sorry, I think I have
27 confused the issue. Only 2 were probably regular
28 users of amphetamines. As I recall, the individuals
29 came for other reasons. They did not come as I said
30 and wanted help about amphetamines. I know of individuals

who are using amphetamines, and who I would say needed help, but they are not seeking help.

THE CHAIRMAN: They are not seeking help anywhere to your knowledge?

DR. BODDIE: To my knowledge, no.

THE CHAIRMAN: And since there are no drop in type of facilities, not likely they could find the help anywhere else?

DR. BODDIE: I don't see how they could. There are a small number of members of our community who are getting into pretty great difficulty, or are likely to get into pretty great difficulty with amphetamines, and (a) they don't seem to seek help or wish to seek help as I hear it, and secondly, there is nowhere to go. And I raised this question not perhaps on too much evidence as to whether or not these individuals heavily involved with speed, would perhaps seek help at a drop in centre, at least in its initial stages, but I don't really know the answer to that question because I have no experience to draw from.

THE CHAIRMAN: What do you think about the number, or what is your impression of the extent of use?

DR. BODDIE: My impression is it is small in comparison to the use of cannabis products and LSD.

THE CHAIRMAN: On the figures that Dr. Parsons gave us based on the questionnaire of roughly a total of 150 cases of which there were 15 cases of amphetamines, and roughly 10%, and is there any sort of sense of this as a growing problem? What is the relative

1 sense of priority? We go into some communities and they
2 say"this is our problem." For instance, in Halifax
3 yesterday they said, and several people said, "We feel
4 that speed or the increase in speed is our most growing
5 problem." And yet in the other parts of the country,
6 there is no speed problem, so it varies regionally.
7 What is the sense or relative importance of speed here?
8 DR. BODDIE: My impression is that at
9 this time, it is, relatively speaking, unimportant, and
10 that in numerical terms. At the same time I have to
11 remember there was at least a two year lapse between
12 the presence of the hallucinogens in this community
13 before individuals (a) began to seek help and (b)brought
14 us any certain emergency type of cases and another six
15 months or so before anyone would begin to seek help in
16 order to get off of acid. Now what the implication of
17 this is for the amphetamines I don't know, but I
18 suspect there may be some similarity. In other words,
19 there is possibly an accelerating problem and that
20 hasn't accelerated to the point where individuals are
21 seeking help.
22 MR. CAMPBELL: In your reference to
23 speed use here, Dr. Boddie, are you speaking primarily
24 of oral amphetamine or intravenous amphetamine use?
25 DR. BODDIE: Well, I think I may point
26 out I haven't seen these people with whom I have
27 knowledge, but I think both, and I really don't know.
28 But I do know there is intravenous amphetamine usage.
29 MR. CAMPBELL: In your practice do you,
30 or from what you hear from college, has there been any

1 tendency among adults, who, let's say, began amphetamine
2 use as diet pills or for reasons of this sort, to
3 develop a dependency that has led them to go around
4 prescription shopping from physician to physician, or
5 try and increase the availability of amphetamines?
6 DR. BODDIE: I don't know the answer to
7 that question. I am more involved with youth and
8 children than adults. I do know there have been some
9 forced prescriptions and I don't know whether the
10 Pharmaceutical Association is represented or not. They
11 would have that information. They would have some
12 theft from drug stores of diet pills, but I can't
13 answer that question.
14 MR. CAMPBELL: What about drugs that are
15 non-prescription drugs for sale in pharmacies that have
16 psycho-active properties? Do you see any problem with
17 these?
18 DR. BODDIE: Yes, I do.
19 MR. CAMPBELL: What sort of problem do
20 you see?
21 DR. BODDIE: This is a question I am
22 not really prepared for, but I have seen one unsuccessful
23 attempt or one attempted suicide, and I forget what
24 the substance was. I have seen ,and this has come up
25 again coincidentally, individuals who have brought some
26 kind of pep pills. Whether these are available or not,
27 I am not familiar with, but you could buy this
28 stimulating substance and these were purchased and used.
29 For instance, students using them cramming for their
30 exams.

MR. STEIN: You mentioned earlier your concern about the lack of cooperation re different persons in the community who hoped they were going to be involved working with individuals who were having difficulty. You inferred, and I would like to hear more about this, that it might be possible to do a better job of cooperating, and I think your comment suggested that perhaps in the larger cities where this has been or may have been worked out --- did you say that?

DR. BODDIE: That is my impression.

MR. STEIN: My impression is it's probably the other way around, that the larger cities are even --- there are even more difficulties and more fragmentation. But nevertheless, what locally is your experience around this? In other words, are you able to spell out a little more how you would like to see something develop? Would you, for example, see utility in a branch of Government, some department, having a coordinating function? Would you see this as a private sector or something that should come from the private sector of the community, initiative, that sort of thing?

DR. BODDIE: The problem to which I am referring is not too well formed in my own mind, and that is probably the number one problem, what is the definition of the problem. However, it seems to go something like this: that there are young people who want, say, drop in centres, various kinds of street level services set up. There are service clubs, professional and others ,who want the same thing, that are interested in trying to do something. In the beginning,

there was some problem in even meeting, and that worked out and it was possible for the various groups to meet. The professionals, the service people and the youth. This was worked out. But then the ways and means of compromising, cooperating and getting something done seemed to me to present some difficulties in terms of attitudes of the groups to each other. It may not be a very important point, but it did concern me, and I feel there may be hearings how cooperations can be made as to how to cooperate better.

As far as the specific act on behalf of Government, I am impressed from what I hear about Departments of Youth, and I feel if what I hear is correct, that this type of thing will be very helpful.

MR. STEIN: Where in particular?

DR. BODDIE: I understand in Halifax.

MR. STEIN: Particluarly Nova Scotia?

DR. BODDIE: Nova Scotia. And from what I hear of it,and I talked to many people over there, is that it works very well and is a good thing.

DR. LEHMANN: May I ask you what do you mean by "it works very well" and "it might be quite useful"? Useful for what?

DR. BODDIE: Promoting cooperation between youth, community agencies and Government agencies.

DR. LEHMANN: So you are speaking now of problems of youth in general, psychiatric or behavioural problems, quite unrelated to drugs?

DR. BODDIE: In a sense I am. This I think is a developing perspective of my own; but I don't

really see this altogether as an entirely separate problem, that is, the problem of the non-medical use of drugs.

DR. LEHMANN: Is that what you say, you are convinced that youth has problems in adapting to present day society and they should be helped; this informal facility should be developed for this? One of the manifestations might be non-medical drug use and therefore you would theorize that by having drop in centres for instance, any problems that are existing now or may arise in future on non-medical drug use would be reduced by having these preventive facilities?

DR. BODDIE: That's what I meant.

THE CHAIRMAN: Doctor, on the question of cause and the extent to which the problems can be reached by medical treatment, could you tell us something about your experience with the cases involving the hallucinogens such as LSD. I think you said those were cases in which the people presented themselves for help; that's what my notes say. What kind of help, and how effective can medical expertise be in relation to difficulties you encounter there?

DR. BODDIE: Well, a small number, and I am sorry this is not a very detailed study with precise breakdowns, however, I will do the best I can. A small number of individuals, some perhaps --- less than half a dozen, phoned directly for help in connection with a bad trip. So that is one group. My recollection is that was all that was wanted and there wasn't anything to follow up. Other individuals came because of other vital

1 problems and the question of drug use came up as a
2 coincidental matter.
3 Others came because of specific anxieties
4 related to having used LSD, had they damaged themselves,
5 had they imposed some hazard on their future potential
6 in children ,should they have this sort of thing.
7 THE CHAIRMAN: How do you handle the bad
8 trips, Doctor?
9 DR. BODDIE: Those in which I have been
10 involved, I go there and I attempt to administer,
11 depending on the severity of the situation, either
12 orally or intravenously, valium. Two individuals have
13 been seen in the out patient department in one of the
14 general hospitals in the city, and one of these
15 individuals was extremely violent and had to be trans-
16 ferred for his own protection to a mental hospital
17 unfortunately.
18 THE CHAIRMAN: Was this someone on LSD?
19 DR. BODDIE: I suppose so, but it's
20 difficult to identify the substance. It was understood
21 he was on LSD. But the whole series of events involved
22 emergency conditions, and eventually, and as I say,
23 unfortunately the police had to be involved because of
24 the physical violence associated with the occasion.
25 DR. LEHMANN: How long did this particular
26 patient stay in the hospital?
27 DR. BODDIE: In the out patient depart-
28 ment? I believe a couple of days.
29 DR. LEHMANN: It was only a short bad
30 trip?

DR. BODDIE: As far as I know, but I haven't seen the individual.

DR. BHATTACHARIA: May I answer some of the questions you have raised?

THE CHAIRMAN: Could I get the spelling of your name, Doctor?

DR. BHATTACHARIA: May I give it to you later on, sir?

THE CHAIRMAN: I know what you mean.

DR. BHATTACHARIA: The problem in Newfoundland is that we really have nothing at all to deal with the drugs. There is no provision yet. It has been talked about to an extent, but nothing has been done and I don't think anything will be done in the next two years at least. Now, I may answer this if anybody challenges me on these issues. I myself have seen 36 cases, and in Newfoundland, because we have no real provision to deal with them, we often alter the diagnosis. That is to say, if we find a person is acting in a schizophrenic manner, we prefer to diagnose this case as schizophrenia than to diagnose it as suffering with LSD reaction. So therefore, it would be not from the statistics point of view --- I don't think your comment should go on in thinking we are really talking honestly and frankly, because we just have no means of dealing with them. I have seen 19 people who have taken some kind of drugs including 3 LSD, and these were the people who saw me after office hours, or on a friendly basis; the reason, if they came to the out patient department and I saw them, I had to document it, and so

1 forth. So the individual requested to see me, or the
2 parents requested to see me, and these people have had
3 no other drugs like amphetamine. Now most of the cases
4 we had, that is, I just looked up yesterday the
5 admission numbers, we had 7 altogether that were
6 admitted and they were not necessarily LSD or amphetamine
7 or any specific drug. It seemed they had all of the
8 drugs that are available. So what was the specific
9 reactions in these cases remaining to be judged? Now
10 two of the patients that came from the mainland, one
11 had LSD or whatever other drugs, broke out in an air-
12 plane. Therefore the airplane had to be landed, and
13 the Mounties brought them to us. Another one was
14 travelling from Toronto and had his reactions so to say
15 in transit when he reached Newfoundland. Now most of
16 these cases, how they are treated? The treatment
17 facilities here are still haphazard and is not well
18 thought of, because the psychiatrists ourselves are to
19 blame. We haven't sat down and thought about these
20 problems nor have we really pressed the Health Depart-
21 ment here that we must have a base on that. We have
22 been talking about it, I agree. And these people were
23 in the hospital and they were mainly treated for drugs
24 by individual choice, and once the reaction was over,
25 they were just allowed to go, unless they were under
26 probation, and there were two or three such cases.
27 So if they had probation, what we did is we calmed
28 them down with drugs or other means and once this was
29 so, we kept these cases a few days in the day care
30 centre, and if they behaved well we had no alternative

1 but to let them go. And this is the extent of the
2 treatment of drug consciousness in St. John's at least.
3 Thank you, sir.
4 MR. CAMPBELL: Dr. Bhattacharia, I wonder
5 if I might ask a question; you expressed a rather
6 pessimistic view in your opening remark, and if I
7 remember correctly you said there was an absence of
8 facility, but you went on to say that you thought
9 nothing would develop for either some years, or two
10 years, words to that effect. Could you expand a bit
11 on your reasons for this?
12 DR. BHATTACHARIA: Well, yes sir, I can.
13 I have a lot of connections with individual organizations,
14 and as Dr. Boddie already mentioned, the service club,
15 and my latest information a few days ago, this is
16 almost under the carpet. I myself have discussed this
17 matter about the hospital facilities, and nothing yet
18 has happened, and the youth quite often tell me they
19 would like to do something, but who do they negotiate
20 with? Because they realize, sir, if you negotiate with
21 a pretty sizeable problem such as drugs and so on and
22 so forth, people start thinking what is your interest.
23 So young people in that sense are also have been pushed
24 under the carpet. I mean, look at the presentation
25 today. Most of us here, I wonder how many of us really
26 have any real experience with drugs. I see some of the
27 young nurses and some of the people who really have not
28 advertised this meeting. Not all the people who would
29 be interested. We have a drug problem and I have some
30 criticism of that too, in this place, that we have not

done really to investigate the situation to find out what should be done; to go on, sir, we must have a drop in centre or must have this or must have that, and as you know some of the drop in centres have also been criticized because it identifies who drops in. So what a way it has to be done, and this has not been discussed and I think as it has not been discussed and there are various people I talked to, and they say, "Well, I don't know, nothing has happened, and if a thing that is started some time ago at the beginning of this year still has not got even a basic structure". And I think looking in the past, one would say, "If there has been nothing done yet, and with ten months of this year gone, then perhaps I would then assume that it would take another two years."

THE CHAIRMAN: I would just like to take this opportunity as a matter of information, to inform all present of the list to which we sent invitations including --- where this meeting --- including a copy of the report in case they haven't had an opportunity. I read this list not by way of any criticism, but just for local information, and assurance, reassurance that we have sought to have as representative --- as much a representation of views as possible. I will just read these societies that we sent it on each occasion to the presidents of the society. St. Andrews Society, Canadian Red Cross, The Canadian Junior Chamber of Commerce, the Kiwanis Club, the Lions Club, the Wisemen Club, Federation of Newfoundland Fishermen, Association of Professional Engineers of Newfoundland, Church of

England of Newfoundland (complete list of societies read to which notification of hearing was given).

So that we are seeking in each place we go to assure as far as we can anyone who might have --- we are sending a report to them. This is simply for your own local assurance and peace of mind about the way this matter has been advertised.

THE PUBLIC: Yes. I would like to say in connection with the drop in centre, that there was a lot of work done by a few people, and it was set up and ready to go in operation, but there was no money, and other people whom you would expect in the community to get behind this, they backed down. In Newfoundland, as Mr. Stein said, he felt it would be more cohesive being a smaller place but it's the opposite, because everybody knows everybody else, and they are afraid to put their neck on the plank, or whatever it is. There is a very narrow view in St. John's and in Newfoundland about the drug situation. Some people are interested and others are not. They look on the child that is involved more as a criminal. This is because of the thing you had in the spring. It made people come out in the open more and discuss it more, but you have a lot of people, they feel, "Why should we give money and support a child that goes on drugs?" They don't realize that that problem is just as severe as a child who has cerebral palsy or something like this.

But there was something done, and there

1 was purely a lack of resources and people who got stirred
2 because they were afraid the finger was going to be put on
3 them because they were interested in this and why they
4 were interested.
5 Thank you.
6 THE CHAIRMAN: Thank you.
7 THE PUBLIC: I would like to support this
8 lady on what she says entirely, but I would like to ask
9 Dr. Boddie a question. We talk about the children on
10 drugs; we talk about the drug problem; but do you as a
11 practising psychiatrist have any ideas as to why children
12 begin in the first place? You say drugs recognize no
13 social or intellectual barriers of any kind. But is
14 there any one motivating force as to why children
15 started in the first place? You know, they are all
16 aware that it is very dangerous. I would like to know
17 myself. Do you have any personal opinion, having seen
18 them, as to what starts them off in the first place? Is
19 it a parent problem, school problem, a social problem?
20 Because we as parents have to know, because if we can
21 correct it then we would like to.
22 DR. BODDIE: I am sorry, but I'm not going
23 to be able to answer your question, except in very broad
24 terms, as I have mentioned. Things like experimentation,
25 curiosity, desire for a certain kind of experience,
26 therapeutic trial, the way of associating with one's
27 peers. These are the sort of things that I seem to observe.
28 Sometimes they grow out of other problems, and meet
29 others which will be indeed intolerable.
30 Sometimes family problems; sometimes, but

rarely so, developing mental illness. Many reasons as I see it, but I don't know that I am necessarily the best one to answer your question. These are my somewhat scattered points of view.

THE PUBLIC: You talk very much about the amphetamines, and LSD, but what about marijuana? The children seem to feel there is nothing to grass at all.

DR. BODDIE: I think so, yes.

THE PUBLIC: That is nothing. Do you yourself feel that it is dangerous?

DR. BODDIE: I feel that answering that question, one has to look at the individual, frequency of use, the circumstances under which they are using, the laws which apply to the use of it, and many other factors.

THE PUBLIC: Thank you.

THE CHAIRMAN: Excuse me.

THE PUBLIC: While you are on the subject of the youth clinics --- I am a Newfoundlander, but I happen to be living in Montreal, and I am on the Board of Directors of a Youth Clinic in Montreal and we have just started --- well, we have a Youth Action Committee and we just started our clinic six weeks ago, and when I say about money, Montreal is just as hard as here in St. John's to get any money. It is in the west end, it is on(Onge and Gerrard,)and we have went out and we have slugged for that money. And this is what you have to do in St. John's. It concerns me greatly to come down and see people here, and I went out and put my head on the block because I happen to like young people, but

you can go around the neighbourhood collecting cans of paint and carrying them down to the clinic so they can paint their walls. And you beg for furniture. You send out letters, and bit by bit. Our administrator who is only 20 years old, he was associated with Cool Aid in Vancouver and the John Manns clinic. He gets $60.00 a month and this we sort of grab around. Fine. But we feel we are doing some good and to hear the Doctor speak --- now I am a lay person, but since I got into this last February, I have probably seen more speed problems, more LSD problems. I am actually being the most adult adult of our group in the background. But I have seen the problems, and I've seen the problems of speed growing in our areas which is sort of a middle class area, and it is getting bigger and bigger all the time, and they are coming for help now. But it is a bit late for some. But the thing is they come in and we have a doctor three nights a week, psychiatrist one night, G.P. one night, medical, and then the other time, our workers, the youths themselves can talk them down; not send them out to the mental hospitals; we just wouldn't do that. We do our best. When they had the pop festival in Mosport, our group went as a group and worked there. We made up sandwiches. This was in Montreal and this is something I have really never done in my life before, but it has to be done and it has to be done here in St. John's. And I feel either the Federal or the Provincial Government, and I am saying this to the LeDain Commission --- I have read your book thoroughly --- but they can give us some help because

the youth are very important people, because they are Canada tomorrow, and I feel that we can help them. And if the adults, and if they have to believe, so what long hair? The clothes. That doesn't matter; that is not important. It is the person themselves. Underneath some of these they are really beautiful people as my children say, and this is what I would like to say. It bothers me that here in St. John's there is so little done.

And thank you very much.

THE CHAIRMAN: Thank you. Could you tell us the name of the drop in centre?

THE PUBLIC: Yes. We are the West End Youth Action Committee, and our drop in centre is just the West End Youth Drop --- oh, they are calling it Heads and Hands now.

THE CHAIRMAN: Heads and Hands?

THE PUBLIC: It is on Gerrard.

MR. CAMPBELL: Is that the one Mark Early is involved in?

THE PUBLIC: Mark Early is one of our most terrific workers and this is the same group. I think he gave you a submission. He also had a meeting with Mr. Aldman, the M.P. for the district, and six adults, and we discussed your report from 7:00 o'clock at night until 12;30 in the morning.

DR. LEHMANN: Do you have one psychiatrist or several?

THE PUBLIC: Different ones that come at different times from the Jewish General and the Queen

Elizabeth. They are giving us a back up service.

THE CHAIRMAN: Thank you very much,

DR. BHATTACHARIA: Dr. Boddie and I offered our help should the drop in centre be formed; is that not correct? You and I both agreed to give help?

DR. BODDIE: Yes, that is correct.

THE PUBLIC: This perhaps doesn't follow up entirely on Dr. Boddie's presentation, but I will not be able to be here this afternoon and it's very short, and it's more in the form of a question specifically to you, Mr. LeDain, because in seeing you on Montreal television I followed you along your work on the Commission. I am very impressed by your sincerity in approaching this, and seeing it not really as a lawyer being sent out to find facts, but as a human being concerned with the social problem that is very important in Canada now, and needs solving. In light of the Government's reaction or the publicizing of the Government's reaction to the interim report, lack of action, let's say, not only under terms of "legalization" of drugs or possession, not only to drug centres and treatment, and so on, is it not possible that when the final report comes down,and granting the possibility there might not be a great deal of Government action on the recommendations, do you feel you are going to have to be prepared to go on beyond the terms of reference which are simply to report and recommend and to take some kind of, and I don't know what kind, of concrete action on your own after the expiry of the mandate to see that it is implemented as a

1 human being concerned? You have seen the problem perhaps
2 more than anyone in Canada, or perhaps all of you
3 together. Would you feel you would have to take some
4 action outside of the bounds of the Commission to get
5 something done?
6 THE CHAIRMAN: Well, you have covered a
7 lot of ground there. In replying to your question to
8 the best of my ability, I don't want to make any comment
9 on Government action or non-action, or necessarily
10 concurring there hasn't been action rapidly enough.
11 First of all, we are not fully aware of all of the
12 initiatives being taken at the various levels, the
13 recommendations, e.g. ,research and so on, support for
14 innovative services. We are not aware of precisely
15 what discussions have taken place in caucus or in
16 cabinet, you know. We are still independent of the
17 Government and we don't have contact or discussions as
18 to what they may or may not do. And further, as I
19 think Dr. Boddie indicated, the influence of our work,
20 or else the work of the Commission and those that are
21 assisting it both on the staff and in the public, has
22 a broader perhaps impact or influence socially than
23 necessary legislation; that there is a general climate
24 of opinion; that there are all kinds of initiatives for
25 responses at different levels that may be influenced
26 constructively we hope. So with all that reservation,
27 I will try to answer the very personal and direct
28 question. We ask other people very personal and direct
29 questions, and I guess it is only fair that we should
30 receive a few from time to time. I can't speak for my

colleagues, needless to say, as to what view we will take individually of our personal responsibility when our mandate is over which will be roughly at the end of May. We are now preoccupied with our final report to the best of our ability. But speaking for myself, I certainly don't think that one can go through this experience without being profoundly affected by it personally, and let's say we are developing a very keen senses of responsibility and concern, and it is hard to imagine that one could cease to carry this sense of responsibility and it is because when the mandate is over, the responsibility of a Commission is over. So I guess we will have to determine what we will do as individuals or what we feel we must do. But let me say this, and I hope I am right in this assumption: I proceed on the assumption now that we will be free as individuals once we have discharged our mandate to do what we think we should do as individuals. I wouldn't find it easy to discuss any other view of our position at this time. But I suppose when that time comes, we will have to personally consider just how we can discharge our personal responsibility and exercise our personal freedom consistent with, I suppose, our responsibility which will always be there for what we did as a Commission together, and I suppose you would never want individually to undo or undermine what we did as a Commission. At the same time, I can't believe that what we did as a Commission should prevent us from continuing to do what we can individually. So it is just a matter of individual choice and assessment of

1 what has to be done. But I don't disguise, and I
2 wouldn't attempt to conceal the fact that this has
3 become for us much more than a job work. You can't
4 work together for this period of time in looking at
5 your society, and mood problems involving ourselves as
6 well as anyone else, without profoundly affecting your
7 outlook, and as I say, developing in you a kind of
8 ethical commitment; sense of responsibility. So we
9 will just see how that is discharged.
10 Dean Campbell?
11 MR. CAMPBELL: Dr. Boddie, perhaps at
12 another level, but presumably in your practice and your
13 colleagues' practices, who also see a drug problem in
14 the sense of the reaction, the anxiety, concern of
15 parents, is there anything you care to say about the
16 nature of the reactions that are occurring there; the
17 resources; the problems that may be occurring in their
18 lives?
19 DR. BODDIE: Oddly enough --- the occasions
20 on which parents have approached me actually is more
21 involved with parents than with the members of the young
22 individuals that have approached me personally. Actually
23 it has really been only, I suppose --- well again, less
24 than half a dozen that are graver problems in the family
25 environment than the fact at this particular point, and
26 the individual was using some form of drug and that
27 these problems have preceded their request for consulta-
28 tion. And again it might be too heavy with the outcome
29 in terms of trying to intervene with any success with
30 the problem of the family. So I don't feel the problem

1 is a drug problem, but rather family problems.

2 MR. CAMPBELL: Let me just change the

3 ground of the question then, to approach you as a

4 citizen observing citizens. You must observe people

5 in a circle of friends or acquaintances, and you must

6 say things about this particular topic. As a trained

7 person, what is your view of the nature of adult

8 reaction and the sources of adult reaction?

9 DR. BODDIE: My fear is not uncommon ---

10 I don't know whether it is the most common fear reaction.

11 A sort of total reaction to anything that tends to be

12 conventionally associated with drug use, clothing,

13 style, one thing and another---sometimes I feel an

14 attitude of implicit encouragement and my patient

15 sometimes observes this which I feel is responsible.

16 Curiosity in adults are certainly present. These are

17 some of my own personal observations just as I go

18 through the community.

19 MR. CAMPBELL: When you use the word

20 "fear", is this a fearful consequence for another

21 generation, or is it a fear that reflects concern about

22 deviance or is it a fear for society? Is there any

23 particular level of nature of this fear?

24 DR. BODDIE: As I understand, it is the

25 fear that is unknown. We all know about alcohol. I

26 am not so sure about that, but this is what one hears.

27 "We all know about alcohol". But this is something

28 different, we don't understand, so therefore we are

29 afraid. I think that can lead to various other things

30 constantly, and sometimes very punitive types of

1 responses.

2 THE CHAIRMAN: I would like to come back
3 to that question I put to you some time ago, Dr. Boddie,
4 about the limits of the medical resource to deal with
5 the underlying causes and the lady asked the question
6 about the causes, and your answer reflected a variety of
7 explanations which one has to refer to . But as a
8 psychiatrist, what do you feel you are able to do about
9 the people that come to you with these underlying
10 problems you mentioned. You referred to family problems
11 at times, problems of adjustment. Are there any other
12 --- I mean, I guess what I am really asking, I am trying
13 to find the limits of psychiatric resource here when
14 you see other resources in this community which can
15 offer some alternatives to drug use; some assistance to
16 people who feel powerless.

17 DR. BODDIE: I feel that I, as a psychia-
18 trist, am trained to give a certain kind of help which
19 has maintained limited application. Again, a psychiatrist
20 generally will apply themselves in different ways
21 depending on their orientation. They might take their
22 orientation in response to a question as based on an
23 interesting --- working on an individual on an indivi-
24 dual basis in a psycho-therapeutic type of relationship
25 or intervening at the request of the family as a family
26 group. So this is where a psychiatrist can best do this
27 in professional countenance. As a citizen shall we say,
28 some special knowledge, with some special knowledge,
29 through my work I can cooperate with community groups.
30 Other psychiatrists may be more oriented to facilities

attached to hospitals, clinics and so on. And these groups and individuals practising as I do, I think, can provide advice and back up to what may be called voluntary social groups who are working with youth. Be available for consultation, be available for emergency help, giving referral for some reason to emergency agencies and so on. I think this is the way I have seen it, and its influence (inaudible).

DR. BHATTACHARIA: Is it not also at times because, say, a person has taken marijuana had come in contact with psychiatry and they think the medical profession is very eager because it has an involvement to say, "Ah, these are the problems; that is why you come to me and you have been taking marijuana, therefore marijuana is equated with your problem."

DR. BODDIE: I don't think so.

DR. BHATTACHARIA: I have had several psychological testings done on these people, working on fear, and it did not seem to me to be related to the problem. And also ---

THE CHAIRMAN: Excuse me, what was not related to the problem?

DR. BHATTACHARIA: I had a group of people on which I had psychiatric tests run and I am not talking about drug addicts, that have taken drugs, and the psychological testing, and my clinical impressions were no different between these two groups. I think you and Dr. Lehmann have said these things.

DR. LEHMANN: Between those who had and

1 who had not taken the drugs?

2 DR. BHATTACHARIA: The adolescent problem
3 that we talked about, it has been universal and will be
4 universal. It just happened that there is a drug and
5 they are taking it. But I do not think that the doctors
6 here are capable of saying, "These problems are related
7 to drug taking," the same way as we have said before,
8 the one drug leads to another. How can we then say that
9 for 20 odd years or at least over 10 years we have
10 given people, parents, housewives, all kinds of people,
11 methadrine, dexadrine and told them, "This is a good
12 drug for your depression." We have not seen these
13 drug people that have come into LSD. I have treated
14 more than 1,000 people with LSD treatment and I have not
15 seen a single case, and I have written this in the
16 journal, that led up to further taking of LSD when they
17 were not under psychiatric treatment. This does not
18 follow. I think this is a completely sociological
19 problem. It is not in that sense that I think to answer
20 your question that the psychiatrists can give authorita-
21 tively any answer that there is a cause and effective
22 relationship.

23 DR. LEHMANN: If I may question you a
24 moment on this to something which to me appears quite
25 important. This was on a remark you made before, namely,
26 you said that here, because these --- I think these were
27 your words: "Because there are no facilities dealing
28 further with the drug problems, the diagnosis is made
29 of, let's say, schizophrenic breakdown" when it might
30 really be a drug induced psychotic episode. Now, this

1 sounds like the opposite of what we have been told is
2 happening in such countries as India, for instance,
3 where many, many patients are in the hospital diagnosed
4 officially as cannabis induced psychosis, simply because
5 there are not enough facilities to make a proper
6 diagnosis and since many of these people do take cannabis,
7 they automatically are called cannabis psychosis. Now
8 you claim the opposite is happening here. There may be
9 a drug induced psychosis, but because it would be
10 inconvenient, because it would imply the need for further
11 follow up, it is called schizophrenic psychosis. How
12 often does it happen? And you just now told us that
13 psychiatrists are really not capable of seeing a specific
14 causal relationship between drugs and breakdowns. Now,
15 the two things, how would you reconcile them?
16 DR. BHATTACHARIA: Whenever you question
17 us and take us down, we always have to come up by
18 saying, "They are not all my personal experience. I
19 did not make the diagnosis in all of the cases I have
20 seen, nor have I treated all of the cases I have seen,
21 but these 19 I have certainly dealt with." We cannot
22 say that. All I have done as soon as I knew, I looked
23 through what was the diagnosis and there it was in
24 small writing, this could have been, the patient could
25 have taken drugs. This is the reason, as I say, that
26 the psychiatric statistics aren't all that reliable yet.
27 Recently I was in India and I have seen
28 American, Canadian, English, German and I asked about
29 50 or 60 people, I asked the psychiatrists there, and
30 a lot of these people, they are not on amphetamines, they

are just having hashish and things like that. And one of the things most of them told me, they feel, I am saying, "Well, I will die here and if I go back to our country, I will die in the lock up. So what?" I think this is what society has to think of.

DR. LEHMANN: You see it primarily as a sociological problem, and secondly as a psychiatric problem?

DR. BHATTACHARIA: I think there would be a group that would have a certain psychopathology to deal with, and I think in Britain and all over the world that treatment of drug addiction is the failure, because those who have pathology, I think these like schizophrenics, we cannot really control them to an extent, but we cannot do any more. Alcoholics we can do something, but not more, and these are our failures. But there are many more people who have taken drugs and would take drugs and they do not come to us; they will not require our treatment and we never know about them. It should be equated to prostitution if you like.

DR. LEHMANN: It should be what?

DR. BHATTACHARIA: Equated with prostitution.

DR. LEHMANN: I don't see that.

DR. BHATTACHARIA: As I say, society says prostitution is bad you ban it and it goes on. How many people go, how many people do not go? People, statistics are wrong again, and they have venereal disease, and it is these people that are then assessed, what kind of personality they are. But the guy who

1 doesn't go into this category, doesn't ever know. So
2 we are only taking a small fraction and we are giving
3 this an enormous expansion which is possibly not
4 scientific in my opinion.
5 DR. LEHMANN: Do you see it as one of
6 your tasks or a psychiatrist's tasks to instruct the
7 public on what you just told us? Namely, that in the
8 public there is a very widespread conviction, probably
9 right here in the room, that the taking of drugs in
10 itself is either a symptom of severe or other severe
11 psychiatric disorders already that they need treatment
12 for; or that it will invariably lead to a psychiatric
13 disorder? Now your opinion is expressed by many other
14 psychiatrists, is that not so, but that sociological
15 and other personality factors really make for the
16 disorder, not the taking of the drug.
17 Now, do you consider it as one of your
18 tasks to work on the adults, not the drug taking people?
19 That is another task, drop in centres and so on. And
20 there is also the task of course of providing factual
21 information about drugs to the young people who might
22 be taking it. But the task of instructing the adults
23 or parents of your concept of psychiatric disease and
24 how related or unrelated it really is on drugs, do you
25 consider that as one of these tasks, and if so, what
26 are you doing about
27 DR. BHATTACHARIA: I think that the
28 adults don't want to know the problems of the young.
29 This is my very personal feeling. One may reject that.
30 If we are going to --- just look at the

1 situation. We are two psychiatrists, we are talking,
2 but we are only referring to what I really don't know.
3 I think we first have to get this information and
4 psychiatrists can play a role in this, because they are
5 professionally trained to gather information. It may
6 be from young children; it may be from parents or any
7 organization; it may be. And if we can get the informa-
8 tion and honestly say --- we have already in India all
9 this work done about eighty or ninety years ago. The
10 Mayor's Commission in America went into that. We have
11 some information; we can gather more. How we can do
12 that in our working capacity, I think the Government
13 should allow to form individual psychiatric ---
14 psychiatric based committees in every province, and I'm
15 talking now for Canada, and allow them like your Commission
16 to have subcommissions that can sit and talk individually
17 with school children or different age groups, and gather
18 this information which would be more true than seeing a
19 patient in an office. And if we were allowed in, say,
20 six months with full pay, if we were allowed, possibly
21 we would be able to give you a paper that would be much
22 more reliable than it is now. I mean, 50 cases is nothing,
23 or my 26 cases is nothing. These already have possibly
24 some deeper psychopathology, and this is what we are
25 looking at. You know, the drug scene in Canada, that
26 book referred to one of the Californian people, there
27 were 90,000 emergency admissions and only 3 drug problems.
28 If these statistics are true, then what are we talking
29 about? We have to find these facts. This is what we
30 are not doing; we are reluctant to do this; this is what

we don't want to see.

DR. LEHMANN: Why not?

DR. BHATTACHARIA: Because we are afraid.

THE CHAIRMAN: What are we afraid of?

DR. BHATTACHARIA: I am afraid if I give out myself totally, possibly I won't get my pay.

THE CHAIRMAN: Excuse me, you mean there is a difficulty of finding individual time. I mean we are not afraid of ourselves?

DR. BHATTACHARIA: No, I am not personally not.

THE PUBLIC: I would like to say that parents, when it comes to the drug question, the first thing any parent feels is fear. And when you are afraid, you cannot act normally. And I feel myself --- Mr. Campbell was asking and I talked about this many times to many parents, and I have some friends who have children older than mine, and some friends who have children that are younger than mine. And even the parents who have children who are younger fear much more even than I do because they fear that this problem of drugs has not yet reached its climax as far as the children are concerned. And as parents, our first reaction is really absolute fear.

THE CHAIRMAN: What do they fear?

THE PUBLIC: This is St. John's, a city of 100,000 people where everybody knows everybody else. If you have a child who is taking drugs, I would think there are many things that come into play in your mind first. Who is going to find out? Why? What will the

DR. [illegible] WH[illegible] DO[illegible]

[illegible] I [illegible] we are afraid.

[illegible] afraid of

[illegible] afraid if I give

[illegible] I [illegible] pay.

[illegible] Oxford [illegible], you [illegible] there

[illegible] I [illegible]

[illegible] I [illegible] not [illegible]

[illegible] say that

[illegible] the first

[illegible] you are afraid

[illegible] this many times

[illegible] do [illegible]

[illegible] who have

[illegible]

[illegible] this [illegible]

[illegible] our fires

[illegible]

[illegible] from [illegible]?

[illegible] only

[illegible] 100 [illegible] we [illegible]

[illegible] who [illegible] I would think

[illegible]

school do? What will his friends do?

THE CHAIRMAN: Social reaction?

THE PUBLIC: Exactly, social reaction. Because after all, when you marry and have children, our basic aim is to bring these children up to be half decent adults and to live in a community with respect, and I think that the first thing that occurs to us, if it becomes known that we have a child who is taking drugs we are going to lose the respect of the community.

DR. LEHMANN: Is that considered to be indecent?

THE PUBLIC: Yes, exactly. And you feel that you lose --- it's very difficult for me to put it into words --- but everybody around you is talking about you because your child is taking drugs. Now, last year while I was here I was broadly misquoted in the Evening Telegram, and when I picked up the Telegram on Monday I read I had three children on drugs. And it didn't bother me, but my sisters were very upset because they didn't know I had been here that morning and they picked up the Evening Telegram to see my picture in the paper, and say, you know, my sister went to a bridge game and somebody said to her, and said "I didn't know your sister's children were on drugs." Do you see what happens? That we get so terrified that I am sure you cannot act normally when you are afraid, that you would probably like to take your child and put it in a room and close the door and say "Now that might go away, and if I don't talk to anybody about it, or if I don't do anything about it,

maybe it won't happen." And schools, I would suspect that in many schools if one or two children were on drugs, then everybody knows about it and then everybody is talking. And I think if there was some way that parents --- that this fear could be taken from parents, part of the trouble could be alleviated. I am only speaking from my own reactions now and from the other parents that I have spoken to. For some reason or another, they do not look on a child --- when I say a child, 17 or 18, would call going out and drinking four beers as being a problem. One marijuana cigarette? One trip on LSD? That is enough to throw the household unit totally out of kilter.

THE CHAIRMAN: In this list of fears, you haven't spoken about the fear of effects yet? Is that part of it?

THE PUBLIC: Oh yes. I think all parents --- we don't talk about that very much because that is even deeper. Because that is something that you carry with you. If you have a child who has drugs --- I don't see myself able to go out and say to a child, "Do you think you are damaged because you have taken drugs?" I think it is something that the child will worry about and the parent will worry about, but I don't think they would sit down and talk about it.

Another thing, I think the most precious thing between parent and children is the lines of communication. And then once these are broken, they are very difficult to repair. It is very difficult.

I don't want to think the lines of

1 communication between me and my children are broken,
2 they are not, fortunately. I do see a lot of children
3 who cannot go to their parents and say, "I've done this
4 or that or the other thing", and I think this is also
5 a problem, because if you have a problem with drugs
6 with children, then you cannot have a problem with
7 children without parents. You cannot separate one from
8 the other. And Dr. Campbell was worrying what the
9 parents think, you know, and immediately we are afraid
10 and we send out children out into this world, even in
11 the city of St. John's,absolutely terrified,because you
12 never know. You can't keep them locked up. You can't
13 pick them up at school and drive them home and keep them
14 home. Once they get to 15 or 16 you have to let them
15 out in the evening; you have to trust them; you have to
16 trust their friends; you have to allow them to bring
17 their friends in so you know what is going on.
18 THE CHAIRMAN: What do you think parents
19 can do to be helpful in this whole situation? What do
20 you see as their role?
21 THE PUBLIC: Never be shocked at what a
22 child tells you. Now I am only speaking personally for
23 myself. Once a child thinks --- I am not a psychiatrist
24 or anything, I am only a mother. But once a child feels
25 that he cannot tell his mother anything, then he begins
26 to move back a little bit and he will only tell her
27 what he thinks she won't be upset at. And you know,
28 children say the most outrageous things to parents. But
29 I have always tried to encourage my own, and I can only
30 speak relatively between me and my own children. No matter

how outrageous it is, ask me. That is my job. But if the child feels that they cannot ask the parent, or that the parent is going to shut them off, then they are going to move further and further away. I think my children ask me some outrageous questions.

DR. LEHMANN: But you pointed out how terribly afraid the parents are, how they can't think straight under stress of fear.

THE PUBLIC: Yes.

DR. LEHMANN: Now it seems there is very little any expert could do about the fear of social exposure which you so vividly described. Apparently it is a very potent mortal fear. But the other fear that you said was even deeper, namely, that of the effects of the personality, that fear of course could be counteracted by experts. Now, do you see it possible that ---

THE PUBLIC: I would like to think, God help me, if I ever got to the stage where I had a child who was deeply involved in drugs that I would have the courage, say, to go to Dr. Boddie and say, "Look, we have a problem. Give me help." But sometimes, I would think --- again, I bring up the question of a mother who is probably not sure of herself and does not want --- some mothers do not want to admit that there is anything wrong with their child you see. So if the mother has this fear and she won't take the child to Dr. Boddie because she would rather not recognize it.

DR. LEHMANN: The same sort of thing that some woman would not want to go to the doctor if

they have a lump in their breast because the doctor might find that they have cancer?

THE PUBLIC: Exactly.

DR. LEHMANN: Very irrationally, though, I suppose.

THE PUBLIC: Yes. In that sense there are some women who will not speak of that, and if you have a mother who has this kind of shyness, how are you going to get her to admit that she has a psychiatric or drug problem with her child, Now how to get over this, I don't know. I only feel that if the fear and the stigma could be removed, then there is more hope for the help of the children.

MISS BERTRAND: But how would you go about removing that fear?

THE PUBLIC: You mean the social stigma?

MISS BERTRAND: Yes.

THE PUBLIC: That is something I think a woman would sort of have to square her shoulders and say, "We have a problem; let's cope with it." Now some women can do that, and some parents --- let me say some parents can do that, and some parents cannot.

MISS BERTRAND: Yet even if the individual attitude can be improved, say the attitude of one mother in one household, there remains the fact that if your description of the situation is correct, the surrounding, the milieu will go on telling this particular teenager that, "We have known that the family has a problem which is judged to be a sham." So what do we do about that?

THE PUBLIC: Do what you think is right, and let the devil take the hind note. Who can do anything to you or say anything to you if you are doing what you basically think is right. I am only speaking personally, you know, for myself, except that I do think that the fear of the parent is a big force in the child and the drugs.

THE PUBLIC: Could I ask you how much you feel this very, very strong stigma, almost approaching taboo, results from the view which the law takes of this drug use; to what extent does it also result from just a general social opinion of drug use, the effects on society and so on?

THE PUBLIC: The social stigma and the law. I suppose if your child went out and stole a car and he had to go into Court, you would be horribly ashamed too. There again, if you have to take a child into Court, the Court is public, the records are public; that is bad too. How would you get over it? You know. You would probably have to say, "Well, your child is in trouble, he needs you, if you have to go to Court, we will go to Court, we will square our shoulders, and we will brazen it out, and we will go from day to day in the hope that we can cope with it as best we know how."

THE CHAIRMAN: But what would you feel would be the stigma for this fear of social condemnation if the law did not say that the use was illegal? I mean if the law were to be in line with what Dr. Parsons on behalf of the Association suggests, that the simple possession and use not be prohibited, not be made

1 illegal, would that have any significant difference in
2 your judgment on this general climate of stigma which
3 causes a lot of the fear that parents have to confront,
4 these problems of approaching people for help?
5 THE PUBLIC: You see, it is a shame. I
6 said last year that I thought the children should be
7 punished, but then when you look at so many children
8 get conned by somebody else into smoking a cigarette,
9 or buying one. If they have one, they put it in their
10 pocket. If they get picked up, they get caught with
11 possession of marijuana. It seems so unfair, doesn't
12 it?
13 DR. LEHMANN: Perhaps if I may ask you
14 the question again, that Mr. LeDain asked; what really
15 is basically so bad or indecent about taking a drug?
16 Stealing,yes. You know, for thousands of years that
17 has been condemned by society. But drugs haven't been
18 condemned for thousands of years by our society, so
19 what is so bad --- why do you say there is social fear
20 about somebody finding out that one's kids are taking
21 drugs?
22 THE PUBLIC: Because I think in the sense
23 the media has reported so much about drugs, about them
24 being so bad, about children getting into trouble with
25 drugs and perhaps the dress of the children today is not
26 what the parents would like. I haven't run across a
27 parent yet who would prefer their child to have long
28 hair, etc., etc., etc. All of these things are
29 associated with drugs, and the use of drugs.
30 DR. LEHMANN: So it is irritating to

parents because it is different from what they were brought up to?

THE PUBLIC: It is out of the norm. It is not what we prescribe for our children. We probably prescribe for our daughter knee socks and skirts and sweaters, but she is going around in jeans and sometimes no shoes, and going around with her hair untidy. But I think it is wrong now to put a child in prison or to bring him into Court just for the simple possession of marijuana, and as I said before, I think most of the children now just think of grass as grass. They don't really think of it as being troublesome at all.

DR. BHATTACHARIA: May I just interject a bit there? You are asking what is the fear? I think fear possibly, one again has to question psychiatrics. You know Freud and many of us, any deviate behaviour in a child, the parents are to be blamed. So if the child has taken a drug and should the society consider this to be deviant behaviour, then who else is to be blamed but the parents? Now you just imagine to say to a 40 or 50 year old person, two different people, and they have a deviant child and they are looking at the society, and it says, "That is your fault. You reared him that way." And I think this often comes up in parents when I talk to the parents about it,"Why didn't you? Because, well, Doctor, it is our fault." I don't know,if the child looked at me and said, "This is your fault", what would I say? There is nothing to do about it?

THE PUBLIC: There is something in that

too that we think we failed the children, you know, somewhere we have gone wrong and society will condemn us for not bringing the child up right. There is that too.

THE PUBLIC: I am just a layman, however, I feel if the law was removed from simple possession as Dr. Parsons stated, that would remove a lot of this fear. I really feel that a lot of our problems today with these drugs is the fact because we have that law. I think that a lot of teenagers start these drugs purely innocently. And then they may be in lots of instances --- there are kids that have problems with it and kids that do not have problems with it. The kids that don't have problems with it, fine. The kids that have problems with it, the first thing they are confronted with, where are they going to go because of this law? They are afraid to go to their parents, afraid to go to psychiatrists. So if this law were removed, then when the child who is indulging in drugs finds that it has gone beyond his control and he needs help, then he can openheartedly go to his parent or go to his doctor and discuss this. But I think that the child has this overbearing sense of guilt. I feel that these kids, even though they do something that is wrong, nevertheless they have this in them, because that is the way they have been reared, and that is their basic instinct. So all that sort of compounds in on the child. The problem just gets bigger and bigger.

I feel that if the Commission could tell us something that we could do as parents to try and

1 implement your suggestions --- we read what you have
2 said and we read about in papers, but here we are all
3 over the Dominion. What can we do to help the Government
4 see that this is so basic to try to get at the drug
5 problem in the first place? I am not advocating drugs,
6 or anything like that. It is just fear. It is something
7 we have to cope with. But I think we would go a long
8 way in coping with this if we had that law for simple
9 possession removed from our books.
10 I guess I am just saying simply you have
11 heard Professor Bertrand argue, sure it is the law that
12 really is the basis for the taboo or for the condemnation.
13 What I am really saying is, of course there is an offence
14 for possessing marijuana. There is no offence for
15 possessing amphetamines. I don't know about you
16 personally, but would you be less concerned and would
17 you think it is less a shame or less a matter of concern
18 if your children or the children of someone you know
19 would possess amphetamines than if they would possess
20 marijuana? Are you sure it is the law?
21 THE PUBLIC: Well, I think, and you know,
22 I am only a layman. But I think that the kids start
23 out on marijuana and they progress. I know there are
24 people that disagree with this, but I think that they
25 start out on marijuana, but I think that if the law
26 were removed, they would experiment, yes. But I don't
27 think they would get themselves into such a situation
28 where they would have something beyond their control,
29 and if it got beyond their control, then they could
30 get help to get out of it.

MISS [illegible] But what I am really trying to ask is, [illegible] basis for this kind of condemnation, [illegible]dgmental attitude on drugs? Is it really the law? [illegible]ure it is the law which prohibits possession [illegible] particular instance? Are you sure of that?

THE [illegible]ell, I think that most people disapprove [illegible] think this is basic. The same as most people [illegible] of alcohol. But because the law says it is [illegible]t makes it harder for the child to get out of the [illegible]tuation.

MISS [illegible]. But I am saying it is not illegal in the case of amphetamines.

THE PUB[illegible] Pardon?

MISS BERTRAND: It is not illegal in the case of amphetamines, and I [illegible]t think you would have a different attitud[illegible]ld who would have amphetamines on him ---

THE PUB[illegible] [illegible]k most people associate amphetamines with marijuana [illegible] think it is removed altogether.

THE PUB[illegible] drug is a drug.

THE PUBLIC: [illegible]hink they are all included in the mind

MISS BERTRAND: We think it is illegal.

THE PUB[illegible]s I think people think it is illegal.

DR. BHATTACHARJA: I think the one problem people should recognize [illegible] Britain, as you know, until a few years ago, [illegible]mpted suicide was illegal

and the police had to be brought in. The psychiatrists said there ---

DR. LEHMANN: It still is suicide.

DR. BHATTACHARYA: If you remove the legality of it, suicide would drop. That has not happened. People also said in North American to remove the gas poisoning, carbon monoxide poisoning, and if you stop carbon monoxide homes there will be less suicide rate, but it hasn't proved so. I don't think by removing the law as say --- I think many of us don't really understand when you start talking about in terms of law what they mean, but removing the law is not the problem. I think the law has to be realistic. If we consider and the medical evidence is such that these drugs or one particular drug is really harmful, I think there has to be some kind of restriction, but the restriction, is that going to be punishment orientated laws or is it going to be a corrective orientated law. It has to be a realistic law. In some cases, perhaps not because of the drug, but the man who is handling the drug has to be punished or has to be protected, or society has to be protected from him. I don't think just because per se a drug, per se punishment. I think the concept the public at least has, this is something that has to be considered, and I think that that is the point, that whenever you talk to the public, I feel --- they say, "well, remove the law." I don't know what they mean by "remove the law." It has to be restricted somehow.

THE PUBLIC: I was going to say, as a

1 transported Newfoundlander, I grew up here and I went to
2 school here and my social background is St. John's, and
3 then I went and married in Montreal. But you are all
4 mainlanders and St. John's, granted, is part of Canada
5 now, but when you go through the different cities in
6 Canada, and I have lived in many of them, St. John's
7 is still so different. We live here and we have lived
8 and we still are living what people think. My mother
9 who is still here, didn't want me to tell anyone that
10 I worked for this youth clinic, because then the word
11 might get around that my children were on drugs. Now
12 this is the way it goes. She was very worried my
13 daughter might come to Memorial because my daughter
14 weards the weird outfits they all wear, and enjoys
15 wearing them.
16 And I feel that in Montreal, again, you
17 do live --- St. John's thinks it is just St. John's
18 but you do live in sort of "what will the neighbours
19 say." The west end of Montreal is small and they talk,
20 but you still have --- you can sort of, if your son or
21 daughter is in trouble, you can sort of get away with
22 it a bit more. Also we have learned, or we have had to
23 learn to not be as up tight. Now the YMCA in Montreal
24 is doing tremendous work in this with their
25 services. It's not the "Y" with everyone running
26 around in gym shorts any more. And we do it through
27 education. My daughter went to a private school last
28 year. The Head Mistress said, "No, we are not having
29 any talks on drugs in the school. It is not a
30 problem." We knew it was, so a group of mothers stuck

1 their necks out and we went and we demanded that this
2 be given to the girls at the school, and we got a very
3 good psychiatrist who has been working with youth. You
4 have to see you have got someone good, someone who will
5 relate to youth, and you have got to see when you get
6 pamphlets or anything with your educational programmes,
7 that they are the ones --- the kids seem to believe the
8 Ontario ones. They relate to the Ontario ones pretty
9 well. But my own daughter said to me, she is at college
10 now in New Brunswick, but she said, "You told me such
11 and such. I didn't believe it, until I heard it from
12 a youth group in Fredericton." They don't believe
13 their parents. And again you can have the best relation-
14 ship in the house and yet all of the young people,they
15 want their freedom, and you can quite understand, they
16 are 17, 18 or 19. We had a group education --- had a
17 group of girls 10 to 13. They found out I had a 17
18 year old daughter, and the first thing I was asked was
19 "What would you do if your daughter told you she was
20 smoking pot?" So I remembered the thing I had read
21 just before going, one of the things, great big headline,
22 was "Keep cool" if your child tells you, and how you
23 discuss it and why. And I have nephews at college and
24 we have kids at the house. When I went to McGill I
25 started smoking cigarettes, but I had never smoked
26 before. I did it because everyone did it. I am
27 addicted to cigarettes all these years, and I am quite
28 sure it is not a psychiatric problem for anyone. They
29 smoke --- as one of my boys said in the clinic, he said,
30 "You offer a cup of tea , we offer a joint." It is a

1 social thing and you join in and you at least try it.
2 So many of them do. I don't advocate it or anything
3 and they know this in the group that I am in, but it's
4 just not the psychiatrical problem children that get
5 involved, it is all of our kids, many of them actually
6 who will be involved.
7 DR. LEHMANN: Now this psychiatrist, you
8 engaged him for the children?
9 THE PUBLIC: For the ones that need help.
10 DR. LEHMANN: But you just, and the other
11 ladies too, made it very clear that the parents need as
12 much, if not more, education.
13 THE PUBLIC: We are entitled too.
14 DR. LEHMANN: To avoid the deadly impact
15 of the morals, not just the law, but of the custom and
16 what the neighbours think, do you think parents can be
17 psychiatrically or in some other way influenced and
18 educated so they will lose this horrible fear of the
19 morals, of what the neighbours will say?
20 THE PUBLIC: I do feel that they can,
21 because I feel it is happening to a certain extent in
22 Westmount in Montreal with the drop in centre that they
23 have there, because the opposition to that was terrific.
24 And they got a group that worked sort of against
25 opposition and as one mother said, "You really put your
26 neck out, but you believe in something; you believe in
27 the young people." But the parents I feel can be
28 educated and at our school, the parents were invited,
29 in fact they were told to come and the children sat in
30 front and the parents in the back, and this is the way

they have been doing it, and we have had quite a few education programmes, and I would say at our last one there was about 60% parents and 40% young people. This was at St. Ignatius Church in Montreal where we had a panel and where we all went into groups and discussed it. And it's surprising even here in St. John's when young people hear I am working with this the information I get, because they are afraid to talk to me. I was so surprised. But I feel that parents can be educated.

DR. LEHMANN: Do the churches play a part then?

THE PUBLIC: They do. The Catholic churches are playing a very good part in the N.D.G. area. The others haven't come through yet. We are still working hard, I feel it is just general school information, we are [illegible] to the guidance councillors and this relates too the parents. The parents read these pamphlets. And I do feel you have to get over about being up tight about the way that children dress. I mean, beards were in fashion years ago, my grandfather had a beard and this is the way we feel, and we try to get other groups to feel. And yet I am fairly conventional. So you do learn if you like young people and you like your children.

THE CHAIRMAN: Perhaps we might adjourn now. We are going to resume at 2:00 o'clock and we will hear from you in the afternoon.

We will adjourn now.

Thank you very much, Dr. Bhattacharia.

---Upon adjourning at 12:30 p.m.

---Upon resuming at 2:[illegible] p.m.

THE CHAIRMAN: We will resume our hearing now, ladies and gentlemen, and I call now on Mr. John Wood.

Is Mr. Wood here?

MR. WOOD: Yes.

THE CHAIRMAN: Would you like to be seated at the table, please?

MR. WOOD: Yes.

THE CHAIRMAN: Mr. Wood, would you like to begin?

MR. WOOD: Yes. I am the father of five children and this is why I am here today, basically because I am opposed to drug taking. I understand that in a matter like this it is no use me discussing it or arguing against it unless I have some facts, and I only picked up this copy of the LeDain Report on Wednesday here locally. This is the first time it became available in St. John's. I haven't had much opportunity in that time to read it thoroughly, but glancing over it, I found a few things which I feel tend to suggest the whole theme of the mood. To me it seems a little --- perhaps I would say more than a little biased toward drug taking insofar as I don't see anything that mentions the other side of the story. I see in one section here, remarks from a university professor and people in the various other forms of employment on the effects of drug taking. But I don't see any remarks from a mother and father regarding their son who has got hooked. I don't

1 see anything at all from the family side of it, and this
2 is something that concerns me very deeply. I have five
3 boys and they are young and they are well below the
4 age where they understand what drug taking means. But
5 the implications of [illegible] report to me seem to throw the
6 market wide open.
7 Anyhow, these are my first remarks. There
8 was something that [illegible] concerns drug taking that
9 applies to the gener[illegible] heme of things. It is a complete
10 lack of responsibility and on Page 155 there is a very
11 apt remark there. [illegible] says:
12 "A [illegible] involved with drug use expressed
13 it [illegible] this way: "I think maybe it is
14 ti[illegible] stopped all the sociological
15 no[illegible] about social milieu's, and how
16 you [illegible] fell off a horse, and how
17 you [illegible] burnt the pablum or whatever
18 it [illegible] what kind of sociological trip
19 you [illegible] blast off on, and just say in
20 f[illegible] you mean which is 'I get
21 loaded because I love to do it.'"
22 Now here is an expres[illegible]on of a lack of responsibility in
23 a community and not [illegible] in this community, in the
24 whole world. In a [illegible]tzed organization everybody has
25 to be or play a respo[illegible] part in it and here is a
26 complete lack of respon[illegible]bility. "I get loaded because
27 I love to do it." [illegible] this to me is absolutely facing
28 up to the whole situation of living, and the responsibi-
29 lities are there, and this is the situation we have
30 today with drug tak[illegible] It is a complete opposition to

1 the machine of law and order which it represents. People
2 who take drugs to me anyhow, and I think the majority of
3 people ,are synonymous with hippies. And I think when we
4 talk about hippies, and I know I have to be more defined
5 and definite about this, but my understanding of these
6 people are people who are opposing the system and this
7 is their way of expressing their opposition, is to do
8 something like this to defy it and perhaps drug taking is
9 one of the most defiant things you can do. But apart
10 from the defiance associated with drug taking, there is
11 the implications of it, and people who are taking it.
12 These people are not a benefit to society. They are a
13 drudge on society. They are a drain on society. And I
14 personally cannot see that even with the lower forms of
15 drug taking mentioned --- and I forget the name --- you
16 refer to it as hashish probably or marijuana. They are
17 not the type of drugs --- I am sorry, I am trying to
18 think of the word --- like cocaine.
19 DR. LEHMANN: Not hard drugs?
20 MR. WOOD: Not hard drugs. In other words,
21 they do say you can take them and leave them as you go.
22 But it also states the sensations of taking these drugs
23 and also the possibility of what type of sensation other
24 drugs can give, which would lead to harmful effects.
25 The hallucinary drugs, LSD for example, while it may not
26 be a hard drug, could,or it is thought it could produce
27 mutations in the genes for both men and women who are
28 taking it, and this is really bad because it is affecting
29 the next generation, if those people are responsible for
30 any children where those children are likely to have

1 mutations which are already fixed in their genetic
2 pattern, and the follow through from the lesser exotic
3 drugs to the harder ones puts them into a classification
4 of drug taking which is hard to break away from. And
5 I feel personally that drug taking is, as stated in that
6 first paragraph, it is a condition where people do it
7 because they like to do it, but we just can't go through
8 a world like this way. If people wanted to do everything
9 they wanted to do or liked doing, it would be complete
10 and utter chaos. There has to be a sense of responsibility.
11 People can't take drugs just because they have a
12 hallucinary dream or they get away from the world of
13 reality, which is escapism. Things have to be faced
14 in a down to earth, hard fact and this is my feeling,
15 and I don't think the lessening of the restrictions on
16 the taking of drugs is going to ease the situation any.
17 On this point, I do feel that the penalties for drug
18 taking --- not for drug taking, but for drug selling
19 or disposition should be extremely severe, more severe
20 than what they are at the moment.
21 These people, especially with the harder
22 drugs, are handing out death warrants virtually to
23 society and I don't think myself there is a penalty
24 heavy enough for these people. Unfortunately, the
25 people, young people who do go into drug taking, are,
26 I believe, led on to some extent. When I was a young
27 fellow at school, some big fellow was smoking away there
28 and I wasn't and I wanted to be one of the group, so I
29 smoked, and I was hooked to a cigarette. Not really,
30 because I never inhaled it, but I was part of it and

1 this is my feeling as regards the lesser exotic drugs,
2 the marijuana they talk about where the group probably
3 has a puff of a cigarette made of this and somebody is
4 a big shot. But then the sensation was to repeat it
5 again and again, and once this feel --- this delight
6 is being explored to its limit, then I think people
7 want to explore on and find further delights, and this
8 is what leads to more drugs, and I think we have to
9 restrict this not to make it easier to be obtained.
10 These, generally speaking, are my views.
11 I am rather nervous in front of the microphone and
12 perhaps I have overlooked a lot of things I might have
13 expressed momentarily, because I have had to try to
14 make an attempt to mark these passages in the book, but
15 I am personally very much against lessening of the drug
16 laws.
17 THE CHAIRMAN: Well now, thank you, Mr.
18 Wood. In your general opposition to
19 drug use, do you mean that you are against any and all
20 non-medical drug use, or do you make any exception? I
21 assume you are not against the medical use of drugs?
22 MR. WOOD: No.
23 THE CHAIRMAN: Do you make any qualifica-
24 tion in your general opposition to non-medical drug
25 use? Are there any exceptions in your view or are there
26 any degrees of acceptability? Or are you against non-
27 medical drug use altogether?
28 MR. WOOD: I have tried to bring about a
29 level of acceptance on the lesser exotic drugs, but I
30 cannot because this is the first step --- to me this is

the first step. I feel it must be eradicated. If any step is made at all at any level, then it is going to lead to something further. To me this is an escapism and probably can classify it the same as alcohol. But it is an escapism of a different form. Because alcohol after all, even the most depraved person on D.T.'s is only affecting his liver, and himself, but this is affecting society.

THE CHAIRMAN: Well, in what way is its effect on society different from the effect on society of the use of alcohol at the levels that we know alcohol is used today? I don't mean strictly alcoholism, but problem drinking and so on.

MR. WOOD: It is more confined. I don't think problem drinking is a thing that has become obvious to the public at large, whereas drug taking has.

THE CHAIRMAN: No, but apart from its useability from what you and all of us know or we can surmise about the effects of the use of alcohol, normal use of alcohol on society, in what way do you see the effects of the use of a comparable use of, let us say, cannabis as being different? Do you feel the effects on society of the use of these other drugs is going to be different?

MR. WOOD: I think if society could control the use of cannabis in a reasonable manner, I could probably suggest there would be nothing against it. But I don't think society can control the use of cannabis in a reasonable way. I think it leads to other things. I think there are people who are using it who do not use

the full --- who do not know the full implications and I think it leads to other exploratory channels.

THE CHAIRMAN: You don't feel that about alcohol? You don't feel alcohol leads to other things?

MR. WOOD: No.

THE CHAIRMAN: Why doesn't it? Why doesn't the effect of alcohol lead people to think about exploring other effects?

MR. WOOD: I think alcohol for one particular reason is controlled much better. Here in Newfoundland beer is controlled at its take out point at the brewery. The Government levies a sales tax right at the brewery and this is going to be kept check of all the way down the line. I think this handling and control insofar as alcohol is concerned, the Liquor Board also handles the hard liquors, and I think there is a stricter control. The drinking places are visited by the police from time to time or inspectors, and we do have drunkenness,but ---

THE CHAIRMAN: Well, would you think that if there was some comparable control for some other drug, there might be the same ---

MR. WOOD: I think in the case of drug taking it is not a matter of control from outside, but control by the individual to know his limitations and this is what we are experiencing, people who don't know the limitations. You made mention here of a university professor in the east, and he says he takes it, and he is apparently able to control the situation, and there is one or two other people here. There is a man and his

1 wife who take it and enjoy it. In fact they have their
2 little group that smoke marijuana and probably sit
3 around and enjoy their own delights and they go no
4 further than this. But these are probably people ---
5 mentioning these, these are probably
6 he is an educated man and he is surely aware of the
7 effects of drug taking, and what it could possible lead
8 to. From a university professor in eastern Canada, Page
9 292 --- it is rather a long matter because he is deploring
10 the persecution of young long hairs by the RCMP police
11 but --- drug taking seems to have created a society.
12 There is no doubt about it I don't think, and there
13 again we are looking for hard facts, and I don't want
14 to be presumptuous on this, but I feel we must associate
15 in the main drug taking with the hippie society that we
16 have today, and especially more so in places like
17 Montreal and Ontario --- Toronto, in large centres.
18 MR. CAMPBELL: You made the statement
19 with reference to another statement that is quoted in
20 the report when a person says, "I do this simply because
21 I like it."
22 MR. WOOD: Right.
23 MR. CAMPBELL: And spoke of this as
24 irresponsible. What are the proper limits that we should
25 put on people in their doing what they like? In other
26 words, what I want to get at is ,at what point does it
27 become wrong to do something for no other reason than
28 "I like doing it"?
29 MR. WOOD: Well when it starts to interfere
30 with the rest of society, I suppose, and when society

itself has to turn around and support these people because of the condition they are in. Obviously if we are to do all the things that we like doing, we are bound by both civil and moral laws and church laws to follow a certain code of behaviour and outside of this code of behaviour, because the pattern has been established, we start to fly in the face of society and this is why I feel that when you ask where do we draw the line, that opposing society, the norm as we know it, that is where.

MR. CAMPBELL: And yet many of us support these aspects of society, I have often supported a political party in opposition for instance,have taken part in various other things such as chlorination of water, pasteurization of milk, these are all in opposition to the society as it was at that time. But these were not wrong.

MR. WOOD: No, because these were things that were part of society's plan. There is no law that states you cannot take part in the activities of a party that is in opposition. There is no law that states you cannot be an active member in an anti-pollution group. But once somebody becomes a drudge or drain on society due to their physical condition --- I might digress a little bit here. Somebody told me yesterday morning that they were in the Avalon Shopping Mall,and if you are not familiar with St. John's,it is a large shopping centre, and he was stopped by one of these individuals and he was asking for money. This is the type of thing I am referring to where the state of affairs exists from what I have heard in Toronto, in

1 Greenwich Village where these people live in their pads
2 and are generally looking for handouts, and an easy way
3 to obtain a meal or a sitting place, this is where I mean
4 that it opposes society.
5 THE CHAIRMAN: Miss Bertrand?
6 MISS BERTRAND: I was wondering if you
7 would think that giving birth to a child has some social
8 consequences? Does it in some way have bearings on
9 society?
10 MR. WOOD: I don't understand how you
11 mean. Giving birth to a child ---
12 MISS BERTRAND: When somebody decides to
13 be a parent it has social ---
14 MR. WOOD: It has a responsibility,
15 definitely.
16 MISS BERTRAND: Do we a right to interfere
17 with that parental possibility?
18 MR. WOOD: I think as a parent it is our
19 absolute responsibility --- I am not very clear yet on
20 your question. Is it with reference to being a parent
21 or just as a child coming into the world?
22 THE CHAIRMAN: The decision as I understand
23 to have a child?
24 MISS BERTRAND: Yes, to give birth.
25 THE CHAIRMAN: Does society have a right
26 to interfere with that decision since it has a social
27 consequence?
28 MR. WOOD: But surely this is part of the
29 pattern, having the child or not having the child.
30 DR. LEHMANN: Suppose we knew that somebody

1 could not possibly assume the responsibility of having
2 a child, but he wants to have the child. Should the
3 state then have the right to interfere and not allow
4 him to have the child?
5 MR. WOOD: I don't think the state has
6 interfered, has it?
7 THE CHAIRMAN: Excuse me, if I may just
8 clarify this here. I think Mr. Wood you have been
9 stressing the point that this is conduct prohibited by
10 law, and what we are searching for is the reason for
11 your view that this conduct has adverse social effects,
12 so that it ought to be prohibited by law.
13 MR. WOOD: You are trying to draw a
14 parallel?
15 THE CHAIRMAN: We are looking for a
16 reason why the law should prohibit, in effect. We are
17 looking for the reasons for your view, why you feel
18 that has bad social consequences. Now when we are
19 asking about the right to interfere with the decision
20 to have children, is the consequence such that society
21 has a right to interfere? It hasn't actually yet, has
22 it?
23 MR. WOOD: No.
24 THE CHAIRMAN: So that is really what ---
25 DR. LEHMANN: May I ask another question
26 based on something that Mr. Wood said. For instance, you
27 assume that most drug takers are hippies. Then I suppose
28 you would assume that most hippies wear long hair and
29 have special dress because otherwise how would the
30 person who told you about being approached, begging by

one of these, probably because he was dressed in that way. Now in fact an award has been given recently to an effort that has been made by various mental health institutions in the United States in the drug field and one of their --- you might say "gimmicks" --- is to arrange for a meeting with several people who are working with them in the education of the public on the dangers of drugs, some of these people are young people with long hair and jeans and very much dressed, because they like to be dressed this way, as the public thinks drug taking hippies are dressed, and these people would be there and then get up in public meetings and state that they have never taken a drug and never want to turn on with a drug. And perhaps in the same meeting then, somebody in the audience would get up with short hair, crew cut, football playing type,and admit that he has been on dope. Then the public get very confused and rather shaken up because here all of a sudden the idea that you have long hair and are dressed in jeans, he must be taking drugs, but if you have short hair and you are dressed in a business suit you can't be taking drugs, and all of this is thrown over. My question then, after all of this long introduction is,could you really be sure that people who really take drugs are the hippies, and the ones who are dressed in such a way that anyone who is begging on the street, who has long hair, you would think he is also taking drugs?

MR. WOOD: No, you can't be sure, and there is a statement that you have made there and by your own admittance is this, you said the audience was

very much surprised. This is because people generally have assumed that this long hair --- with very good grounds as well --- the long hair type were associated with drug taking. Then you said the man who stood up is clean shaven and had a business suit on, they were very much surprised because this is the general picture that is portrayed of these people who take drugs.

DR. LEHMANN: It is not the reality though?

MR. WOOD: Maybe that is so, and I don't doubt that there are people walking around who are also well dressed and clean shaven who probably do take drugs. I do not doubt this for one moment. But I know there are dangers qualifying certain situations with one stroke and I don't think we can generalize at all in any one situation. I can see that there are probably hippies, people who have long hair and blue jeans, who have probably not even taken marijuana, or not taken alcohol.

DR. LEHMANN: Some of them are very much opposed to it.

MR. WOOD: I am talking in general terms with society as I have seemed to come across it, that drug taking develops this type of individual who is actually opposed. This is expression to society at large because I am opposed, because I am doing the things that you don't like. I am wearing my hair long, I don't wash myself and I don't have a suit on, and this is our thing, I am opposed to society, and to complete that, to take my pot as well. And this is the complete picture. And this is nothing I can give an answer to.

I don't think it is a question of facing society.

DR. LEHMANN: When you say they are not facing up to their responsibilities, you are talking about such things as begging and being unproductive?

MR. WOOD: Right.

DR. BHATTACHARIA: May I just ask Mr. Wood a question, sir? Have you ever had any contact with the hippie people?

MR. WOOD: No I haven't.

DR. BHATTACHARIA: Would you agree that in Newfoundland many people are driving cars without car insurance?

MR. WOOD: I am not familiar with that situation.

DR. BHATTACHARIA: Would you agree with me that your car has 120 miles an hour speed limit and you are only entitled to drive 60 miles an hour, would you tell me why society accepts 120 miles an hour, or why you would pay just to have that on it

MR. WOOD: Well my car won't go 120 miles and I know it will not even get near it. But the fact is that we are restricted to 60 miles an hour to protect the public.

DR. BHATTACHARIA: Well my question is why do they have 120 on the speedometer?

MR. WOOD: I don't know. I think it is irrelevant because I don't think a lot of the cars even can get up that high?

DR. BHATTACHARIA: Do you know that last year in America 6000 people under the age of 40 died in

car accidents, and do you know that is the highest mortality rate of young people in North American car accidents?

MR. WOOD: And may I ask the question here. What condition were these people in?

DR. BHATTACHARIA: Well some of them were alcoholics, some were not, some were driving as perhaps I have said several times with a car so defective, steering not proper, brakes not there, no insurance and more children are maimed by car accidents. I think what you say, I respect in some ways, but how you put it I do not.

MR. WOOD: Well I am not eloquent at ---

DR. BHATTACHARIA: Well I would not --- I think your material is excellent. When you were talking about hippies, and this man said I love it, let me put it to the people to kick around. If we did not marry we would have no reason to commit adultery. Because we are married, therefore we have adultery, which is not marrying.

MR. WOOD: Why, why would I stop marrying?

DR. BHATTACHARIA: Because if we did not marry,sir, there would be no adultery.

MR. WOOD: Right.

DR. BHATTACHARIA: If we did not drive cars on the highway, there would be no accidents.

MR. WOOD: This is true, but this is --- I am sorry, but these questions seem to me to be rather negative. For instance you talk about the cars but I do not understand the relationship. You mentioned that most of the accidents, the cars were defective and this,

1 but the relationship between drug taking and car driving
2 I cannot see.
3 DR. BHATTACHARIA: Well what I am saying
4 is that you have said that drugs should be then not
5 allowed by legislation,law and so forth.
6 MR. WOOD: I did not say legislation.
7 I said I was against drug taking. I did not say I had
8 an answer to it.
9 DR. BHATTACHARIA: How would you propose
10 --- they have only reported what they discovered.
11 MR. WOOD: I don't know, I'm not in the
12 position to even give the answers. The only thing that
13 I can presume was to control marijuana --- this is a
14 very difficult thing. But I do know somebody who is
15 from Lebanon who was telling me there that the law in
16 Lebanon is fantastically strict for even being concerned
17 in drug usage, and that even if an individual is sus-
18 pected of keeping company with somebody who is a drug
19 taker, the penalty against him is so severe that it is
20 not worth encouraging the thought of taking the drugs.
21 DR. BHATTACHARIA: I was in Lebanon not
22 so long ago but you wouldn't like to live in this
23 country because of that type of law, the same type
24 of laws Hitler brought in Europe.
25 THE CHAIRMAN: Mr. Wood, we have been
26 talking --- it seems to me we are talking about two
27 things, both of which are important; one is the general
28 attitude we should have towards non-medical drug use,
29 general judgment we should make. This I would like to
30 pursue a little further with you because you have a

1 position and I want to make sure we understand. The
2 second is what specifically the society should do in the
3 light of what it feels generally about non-medical drug
4 use, including law and other things. We have been
5 talking about both of those. I think my colleague,
6 Professor Bertrand, was asking a question by way of
7 illustration of a general nature which might be
8 expressed, does the society have the right to interfere
9 in every individual conduct which might have costly
10 social consequences. Professor Bertrand rephrased the
11 question in general terms. Is it the mere term that
12 some conduct we have added to social consequences, and
13 does that give us, the society, the right to make some
14 attempt to interfere with the conduct? Before coming
15 back to that, is it your general view that all non-
16 medical drug use must be --- or we must attempt to
17 stigmatize it in some way, or we must be opposed to it
18 morally or on general grounds, all non-medical drug use
19 regardless of relative time, regardless of the degree
20 or level of use, is that your position? Because it is
21 important for us because people have said that one
22 should take a certain position on this, moral position,
23 one way or the other.
24 MR. WOOD: Earlier you asked me,or the
25 Commission asked me practically the same question
26 concerning the non-medical use of drugs and the taking
27 of them other than for the medical use. And even the
28 less exotic, marijuana, I said no because I felt if
29 people start on these drugs, and later on I altered that
30 a little, and said this: that if people could take them

1 and understand what they were doing, their limitations
2 and the effects that it could lead to, perhaps you
3 could relax it, perhaps for the lesser exotic drugs.
4 I certainly think anything that falls within the ---
5 I don't know the name of the type of drugs, but I am
6 thinking of morphine and heroin and these addictive
7 drugs. I think definitely there is no grounds at all
8 for taking them, except for medical purposes. But the
9 less addictive ones like marijuana, well, I think
10 society has to be educated for a starter and I think
11 this has got to stop right at the bottom level, probably
12 right in the schools,because I think this is just about
13 the time people are playing around with it.
14 DR. LEHMANN: Do you draw the distinction
15 then, as you make it clear right now, of narcotics and
16 is your reason because they create a physical addiction,
17 physical dependence?
18 MR. WOOD: They are a physical dependent,
19 and there was another part in this chapter. I couldn't
20 find it offhand, but where they presume what the effect
21 was of taking these addictive drugs is that it mentioned
22 that they thought --- they were not very clear and
23 exact what happened, but they thought that there was a
24 molecular change that took place, whereas in alcohol
25 taking or non-addictive drugs, the effects can be
26 restored to normal after the drug has passed through
27 the body. Whereas with the more addictive drugs --- the
28 addictive it seems an actual change takes place in the
29 molecular structure of the body.
30 DR. LEHMANN: So it is a physical change

1 to you where the point one should make a distinction?
2 MR. WOOD: Very definitely. Because not
3 only insofar as the individual himself is concerned, but
4 insofar as the generations to follow. Because thinking
5 in the case of LSD where it still isn't known for sure,
6 but it is thought some change takes place in the genes
7 or the chromosomes, and this mutation, this change makes
8 itself apparent in the children that are born to parents
9 who have taken this type of drug. And this is a mutation
10 and we are not looking for mutations, we are looking for
11 ones that are going to be in the right direction.
12 THE CHAIRMAN: Would it be fair to sum up
13 your view from what you have said, your view of what
14 our general attitude should be toward non-medical drug
15 use of drugs as follows: there should be no non-medical
16 drug use whatever of hard drugs, the opiate-narcotics
17 and I would assume you would include amphetamines in
18 that?
19 MR. WOOD: You are referring now to speed?
20 THE CHAIRMAN: Speed.
21 MR. WOOD: Right.
22 THE CHAIRMAN: And that while you are
23 prepared to acknowledge that there could be a level of
24 use of soft drugs which might not be unduly adverse;
25 that you feel that there should be no non-medical use
26 of soft drugs because of what it may do to you?
27 MR. WOOD: Right.
28 THE CHAIRMAN: Does that sum up your
29 position?
30 MR. WOOD: That sums up my feelings.

1 THE CHAIRMAN: Could we move to the next
2 step? On the basis of that general attitude, what
3 conclusion do you draw as to the best interest of the
4 society to reduce this general attitude? First of
5 all in law, what do you feel the society should do from
6 a legal point of view, the point of view of legislation
7 to give effect to this general attitude?
8 MR. WOOD: On the last question which you
9 asked which is regarding soft drugs, I don't know;
10 because this is an area which is very fluid. It appears
11 that marijuana is fairly easy to grow; it is fairly
12 easy to obtain. I don't see it is going to be easy to
13 control it. This is why I have to concede upon, as I
14 said before, perhaps people using marijuana were educated
15 as to what it could lead to, it may be all right in
16 certain circumstances, because I realize that in using
17 marijuana it would be very hard to control it. But when
18 we talk about the harder drugs, these are manufactured
19 in chemical laboratories, which are set up by manufac-
20 turing companies for these purposes. I understand that
21 morphine and cocaine are refined from heroin, or perhaps
22 heroin is refined from opium and these require some sort
23 of manufacturing plant. The manufacture of LSD is also
24 generally and the speed type drugs are also chemically
25 manufactured drugs, and they should be, I feel, definitely
26 strong control at the origin --- originating point. And
27 this could be done by the normal methods they use,
28 intake and output and consumption. There are various
29 methods used in other fields where they require to keep
30 an eye on things, and I think the Government keeps a

fairly good check on the level of liquor in the vats that are aging in the various distilleries. I don't think there is any problem there. I think this is the same sort of thing. The Government has strict control over the situation.

THE CHAIRMAN: And what do you? Apart from production and traffic, what do you feel should be done by the Government or by legislation with respect to the use of the hard drugs? To the user, what should be the policy, legislative policy toward the user?

MR. WOOD: You are presuming on a position of where a person has become addicted and unable to ---

THE CHAIRMAN: Is using any of the hard drugs?

MR. WOOD: I understand in England drugs are obtainable on prescription for addicts, but I don't know whether this helps them to break away eventually. I think the situation is they have to break away if they are on drugs, that some programme is to be set up so that they eventually are taken off drugs. By keeping them on drugs for any prolonged period of time as even the situation applies in England is still not relieving the situation; it is only prolonging the agony.

DR. LEHMANN: And if it would at the present time be very difficult to have a method to take them off in future, and that is to a considerable extent the situation now, medical situation, that there are very few methods known. What would you think --- in that case then if there is no programme available to

1 eventually take them off, one should not make the drugs
2 available at all to them.
3 MR. WOOD: If the drugs were made
4 available at all, I would suggest that they would have
5 to be made available under supervision. I have heard it
6 said that in England under the system that is used there,
7 that people manage one way or another to save up a
8 ration and get this and this is how they get it, in one
9 lot or they can take it in one lot.
10 DR. LEHMANN: Not any more.
11 MR. WOOD: Not any more? But this used
12 to be the way and by that they could provide themselves
13 with some handy cash and also provide other people with
14 drugs.
15 DR. LEHMANN: Not now.
16 MR. WOOD: But this system did apply at
17 one time, didn't it?
18 DR. LEHMANN: It isn't now.
19 MR. WOOD: This is what I am saying,
20 supervision would have to be very strict if you were
21 supplying drugs on this type of principle to people who
22 are already addicted.
23 DR. LEHMANN: Would you then agree to
24 the present system in England where many of the physicians
25 have not much hope at the present time that they will
26 in the foreseeable future get the people off the drugs?
27 And they have very strict supervision so that they will
28 not be able to sell it and get ready cash and so on.
29 Now under very strict supervision but on
30 an indefinite basis, would you be for or against

supplying these drugs?

MR. WOOD: I would have to be for. Because after all I am hoping these people will come back. Obviously if you take drugs away from these people, a very serious state of affairs exists both to them and to the rest of society. They have to obtain the drugs somehow or other. If they can't obtain them from the source of supply which is a Government source, then they have to go to a pusher, and this means to say they have to obtain money, and in order to obtain money they are going to resort to breaking or if they are a woman they will have to resort to prostitution and this leads to a breakdown of the moral society, so I have to go along with the first point that the drugs are given to addicts that are taking addictive drugs, and it is given under very strict supervision. I would have to go along with that.

THE CHAIRMAN: Any other questions or observations from Mr. Wood?

MR. STEIN: Just one question on the point you made at the beginning regarding your feeling that there should be an increase in severity of the laws against traffickers.

MR. WOOD: Yes.

MR. STEIN: One of the points we have made in our interim report is that --- or one of the observations I should say, is that there are at the present time persons who are technically guilty of trafficking, young people who are giving other young people small quantities of, let's say, marijuana. And

1 we have made the recommendation that there should be
2 some consideration given to looking at this differently
3 than to those people who are involved in the distribution
4 and the selling of the drug illegally for monetary ---
5 large monetary profit. In other words, we are
6 concerned about the lumping together of all people who
7 are presently dealt with by the Court as traffickers,
8 both those involved in big money making and those who
9 are giving it amongst their friends. We suggested a
10 similar kind of fine as we have for the general possession
11 offence. Now, I am not sure if you have gotten to that
12 part of our document, and that's why I spelled it out
13 here. But do you have any views about the present
14 situation regarding the trafficking law? In other words,
15 would you feel it should be retained as it is regardless
16 of the circumstances; regardless of the particular
17 amounts that are being trafficked --- would you make
18 any distinction?
19 MR. WOOD: What you are trying to say
20 is, should there be two different rulings for a pusher
21 who is in business pushing hard drugs and another law
22 for an individual who is at a party and hangs around
23 for a reefer, but is still technically a pusher?
24 MR. STEIN: Exactly, that is my question.
25 MR. WOOD: Well concerning the hard
26 drugs, I think myself there is no penalty hard enough
27 for a pusher.
28 THE CHAIRMAN: Well the penalty as you
29 know, the maximum penalty is life imprisonment. Are we
30 to infer that ---

MR. WOOD: Well, I would say 20 years of good behaviour, parole, this is not for life -- when you say life.

THE CHAIRMAN: But in other words, it is the question in your view of the exercising of judicial discretion and sentencing and discretion to the parole board, or would you be in favour of replacing the maximum penalty by a more severe one, and I guess there is only one we know of?

MR. WOOD: There is only one we know of, right.

THE CHAIRMAN: Right.

MR. WOOD: Really, on this point, I have to say that if there was a severe penalty that could be used, and obviously it won't be, but if a more severe penalty was used, the death penalty, I think, yes. Because these people are taking this, and it is murder in another form, in its most innocuous form, because these people generally themselves are not takers, they are not addicts. They all know the moral story, but they are there to see life broken down at any expense, and there is some expense involved in this hard drug taking.

THE CHAIRMAN: Well, then, to follow Mr. Stein's question, Mr. Wood, our precise recommendation that he was referring to is in the following terms: "We further recommend that the definition of trafficking be amended so as to exclude the giving without exchange of value by one user to another of a quantity of cannabis which could reasonably be consumed on a single occasion. Such an act should be similar to the penalty for

simple possession."

MR. WOOD: This then again comes back to the question asked before, how do I feel about taking cannabis. As I said before, I would like to see drugs banned, even the softer ones, banned altogether. But I did say that perhaps if people were educated into what could result from drug taking, the implications under these conditions, perhaps cannabis could be softened a little and under those conditions the same sort of thing would apply. In other words, sufficient quantity there, the person would not be convicted under the same penalties as having possession of drugs. But this would all tie in with my thoughts before,that the less exotic drug, and they are in here --- I cannot refute that in here there are educated people taking it and also carrying on a profession and are also productive and are still able to fulfill a part in Canada, they are still taking and producing. In cannabis it is a very hard point, because it is very difficult to control it as well.

THE CHAIRMAN: Any other questions or observations?

DR. BHATTACHARIA: Might I just say that an excellent description of what might happen if you ban the drugs completely is God Father. This is a book written about the Mafia gang and it is a very vivid description. Also one must ---

DR. LEHMANN: Does it refer to banning the drugs?

DR. BHATTACHARIA: This is about illicit

1 drugs and a whole gang, the whole story is based on it,
2 the murders committed and that kind of thing. It is
3 almost like Ann Rand, Brave New World as a matter of
4 fact. Then during prohibition in the 1930's, Al Capone
5 became the richest man and many other people because of
6 this, made their money, because this was given to the
7 gang, and not so long ago there was an article in the
8 local newspaper of the Mafia in St. John's. And I
9 think if it was banned completely we would not just have
10 a story, we would have Mafia in the land, and these drugs
11 are not produced, again it is many, many books, these
12 drugs are made by children in the basement who have
13 grade 9, 10, 11 education in chemistry. So just by
14 stopping production would not stop this drug making.
15 It takes very little to make LSD and speed. Any
16 chemical student can make it so easily that there is
17 no way of stamping it out. This is a fallacious thinking
18 that you people have that we can stamp it out. There is
19 no way of doing it.
20 THE CHAIRMAN: What can be done effectively
21 about it, Doctor?
22 DR. BHATTACHARIA: Could I have one
23 minute to expand on your question? I think we have
24 heard this morning the psychotropic drugs and psychedelic
25 drugs are almost synonymous. I think this is very wrong.
26 They are not the same. What are psychotropic drugs?
27 Psychotropic drugs in my opinion are the chemical
28 straightjackets put on the individual for him to behave
29 within the more of the society. That is psychotropic
30 drugs. Psychedelic drugs are the drugs that an individual

1 takes, either takes them himself to meet the outside
2 world, or he thinks he will expand within, and that is
3 the psychedelic drugs. This is breaking away from the
4 straightjacket. I think this is something we have to
5 understand. Then you have to understand, not just
6 Canada, not just Europe, but the world situation in
7 relation to drugs. People are taking drugs and I
8 suppose you must have met many, but those who are
9 taking marijuana and soft drugs, they are taking
10 Buddhism, Indian philosophy, I met them when I was in
11 India and in Lebanon. With these people there is a
12 philosophical concept that you have in your paper, the
13 philosophy of drug taking. I think the whole situation,
14 I first would like to see that interested people and
15 more so lay people, and the philosophers, sociologists,
16 economists, all people sit together and see the special
17 need which we have not done. We have spent thousands of
18 dollars in councilling for those in the street and it's
19 a start,but we have not yet made anything valuable for
20 drug addiction, drug taking. I think if we are not
21 honestly looking at this problem, any kind of rules,
22 regulations that we put forward is only going to kick
23 our children out of the country to some other countries
24 where they will be able to get --- I think this is a
25 philosophical, sociological problem, and not necessarily
26 a legal problem. Those who are already taking drugs
27 and become addicted, what is their treatment? We give
28 them a socially accepted drug. For a morphine addict we
29 give him methadone. Methadone is not considered, but it
30 is another drug addiction. And anyone that is taking

1 regular pills, they live, but if they don't take their
2 pills they have all the definition of the United Nations
3 drug addiction problem. So we have already invented a
4 society. Coke has caffeine, coffee, tea, cigarettes,
5 alcohol we have produced. I think what we have got to
6 do, leave the young people and stop condemning them
7 because of their long hair, stop condemning them because
8 they want to live in certain ways. Let us investigate
9 in our own mind where religion and philosophy has led us
10 to, and perhaps we have to make a total modification of
11 our social thinking. And as far as I am concerned, I
12 am not pessimistic because people are taking drugs.
13 People have taken drugs through centuries and they have
14 become very productive, in India, in China, and many
15 other civilizations; Egypt, where drug addiction has been
16 known and even in the Bible you will find quite often
17 that Noah had also taken a couple of drops and was a
18 little tiddly. It hasn't ruined anything. When you
19 take the other social evils in relation to drug addiction,
20 I think we are making these people criminal, making them
21 rejected, making them depraved. I think we have to
22 look at the social values and come off our high horses
23 and say, I am a specialist, I know. Look what we did
24 with DDT. We thought it was such a good thing and I
25 would say it is one of the greatest pollutants. I think
26 the aura of specialization has gone. We have to go to
27 the root, we have to ask the people especially in
28 Newfoundland what it means, the crossection of people
29 here are not the people taking the drugs. And these
30 people are not even thinking of it. We are not involving

1 these people. I am not preaching that the drug must be
2 smoked or drunk or anything. This is the social
3 position, a total social view. If anything is to be
4 done more than pollution, it is our social valuations
5 and views.
6 THE CHAIRMAN: Are we to conclude from
7 that that nothing more nor less than profound change in
8 conditions of life, social conditions, is likely to have
9 a significant effect on the extent of drug use?
10 DR. BHATTACHARIA: Yes sir. It is the
11 same way as the Roman-Greek war philosophy, it has all
12 been a period. We are going through a transitional
13 period in our society. We are saying you get drunk on
14 alcohol, smoke and have cancer and drive your car and
15 get killed. All I want to do is have marijuana.
16 THE CHAIRMAN: Well put it this way.
17 When you are talking about these conditions now, and
18 you have the broad general social conditions which are
19 applicable to large numbers of people; not all of us to
20 the same extent; you have the conditions of individual
21 start in life and upbringing of a particular environment,
22 particular family, particular associations, to what
23 extent is this non-medical drug use which we are
24 studying in your judgment a reflection of a fundamental
25 change or difference in the general social condition,
26 the general nature of our life today, to what extent is
27 it just an apparently new but slightly different ex-
28 pression of human conditions, individual human conditions
29 resulting from those particular conditions of individual
30 family life, individual association? In other words,

1 what is really new in the factors and what is, we might
2 say, eternal or essentially unchanged and there are
3 factors that might be amenable to some extent to
4 individual initiative and influence to persons in
5 life, and not requiring a massive social change. It
6 is very hard to make this generalization, but what do
7 you feel about it?
8 DR. BHATTACHARIA: I think that having been
9 brought up on three continents in three different
10 societies and cultures in my life, I think this is a
11 very fast evolutionary process we are going through,
12 and because it is so fast we cannot conceive this. I
13 do not think this is really a youth revolution as we
14 like to believe. I think every society that I have
15 studied that have gone through some kind --- look at
16 Arabash, Margaret Mead's Arabash society which does
17 not have the violences, the hostilities, the aggressive-
18 ness we have in the western world. They have drinks,
19 they have the taboos, they have all these sort of
20 problems. I think what we may be doing is with our
21 present knowledge and your report and so on and so
22 forth, we might be able to prevent the unwary who will
23 become alcoholic and compared to the alcoholic it will
24 prevent him from being alcoholic but he will take his
25 liquor within his needs. This possibly we could do,
26 and because you are bringing in information, because
27 we are thinking about it, we may in another 20 years
28 try and change over this drug addict to something else.
29 What, I don't know. I think it is an evolutionary
30 process and there is no way of preventing it, but we

have to be prepared. Those who are hooked on it, we have to help. Just the same way as we pay money to the welfare, 90,000 people in Newfoundland on welfare. We don't mind paying our taxes because we cannot give them the jobs.

THE CHAIRMAN: But the parents say, "What can we do?" We heard this morning one of the parents say, "You should try to tell us how we can play a constructive role." What is your answer to that? People say something is happening in society, such a profundity of change, such a problem of adaptation to change, this thing is going to run its course and you have to hang on and keep cool, that is one feeling that has been expressed, although it is not too often made. The other is, are you going to say to the parents, well there is not very much you can do except be supportive. Is there anything the parent can do?

DR. BHATTACHARIA: What the lady says is exactly what I would say, be supportive, and if the drug taking is due to a psychological problem, then I would certainly try to treat the main cause. But if it was an experimentation, then I would just say keep your calm, the kid will get over it. To just give the same advice we give our teenage children. Teenage children goes on dating, falling in love every two days, and breaking it apart but we don't become so critical, because we hope at the end of it they will make a successful relationship with someone. We tolerate so much. Illegitimacy in Newfoundland is possibly the highest. There are so many sociological factors that we

1 completely ignore when you are thinking in terms of
2 drug addiction or drug taking. What advice does the
3 mother give when a child says, a 15 or 16 year old girl
4 says, "I had sexual relationships." It should be
5 equated with the same kind of problem. It is an
6 individual problem related with an individual family.
7 What would you have said to Aldous Huxley if he had
8 come here? I don't know. I mean it is the sort of
9 questions ---
10 THE CHAIRMAN: What do you think Aldous
11 Huxley would have said to us if he had come here in
12 1970?
13 DR. BHATTACHARIA: I think that Mr.
14 Aldous Huxley would have said to you, "Sir, the man
15 should be left alone with himself because there are
16 many other dangerous things we are doing, such as
17 climbing mountains; going up in a balloon; trying to
18 cross the Atlantic in an airplane." What does society
19 say to that? Society condones so many evils, that
20 millions of dollars could be spent for a man who wants
21 to go for an expedition or fly his balloon. Why do we
22 allow that to happen? We spend millions of dollars to,
23 as I give you an example, to build a car which is
24 accident prone. We do not tell people, "You have got
25 to have insurance to drive your car." We do not do so.
26 What kind of society is this where I say we are
27 digressing,where you are orientated at the age of 18,
28 you may have to be confronted with death tomorrow, but
29 you have to listen to me today. I am talking mainly
30 about conscription. It has to be equated with this

problem. I think this is why the drug addiction is possibly not getting over to ordinary people, or the children who see so many divergent situations in life that are conflicting, and these ambiguities completely shatter the child so he takes on whoever is a friend to him and starts believing, like the Beatles. And the contributions the Beatles may have done --- I don't know what contributions they have done in this world, but they have copied them, because they apparently offer something. I think this family unity and this kind of thing has to be thought of, not condemnation. They are going on condemning one thing and respecting the other.

THE CHAIRMAN: Thank you, Mr. Wood.

MR. WOOD: Thank you.

THE CHAIRMAN: I call now on Mr. James O'Mara, President of the Newfoundland Pharmaceutical Association.

MR. O'MARA: Mr. Chairman, I have with me on my right Mr. Neil Curtis, the Registrar of the Newfoundland Pharmaceutical Association.

DR. LEHMANN: I am sorry, what association?

MR. O'MARA: Newfoundland Pharmaceutical Association. And I regret we have no formal presentation to make to you at this time, just a few comments to make on your findings and some of the things which we pointed out in our original brief in January. Three or four of your recommendations that concern us greatly in our profession: one was your suggestion or recommendation that certain antihistamines, cough and cold remedies and analgesics such as pain killers, containing

1 phenothyacins which should be available only on pres-
2 cription and not over the counter as at present. This
3 we concur with wholeheartedly. It is something our
4 Association has been asking for for years, and I think
5 that possibly you should take this even a little further
6 and tack on some other O.T.C.'s, over the counter items
7 as we know them, and include some of these in this.
8 The second one is that amphetamines and barbiturates
9 should be subject to closer production, import and
10 prescription controls, but the one area of particular
11 concern to us here is the prescription control area,
12 and this certainly should be tightened up, and we agree
13 with that in its entirety.
14 The third one is your recommendation or
15 suggestion that physicians should be required to give
16 out medical license numbers and the patient's social
17 insurance number on all prescriptions to discourage drug
18 abuse. Now someone mentioned this morning here, and I
19 think it was Mr. Campbell, and he was talking about the
20 so called doctor hunters, the patient who travels from
21 doctor to doctor, getting prescriptions, sometimes called
22 the same thing, and I am sure you recognize the fact it
23 is almost impossible for us to control this. We have
24 several instances recently in the past year, but it is
25 still very, very hard to control. Now in a city of this
26 size where probably most pharmacists know most doctors
27 and vice versa, and where they readily recognize their
28 signatures, of course this still doesn't preclude that
29 there could be forgery of any doctor's signature. But
30 I think that this suggestion that to record the medical

1 license number is a very, very practical suggestion and
2 I think that should also be taken even a step further,
3 in that both the medical associations and perhaps on a
4 national scale and the pharmaceutical associations
5 should get together to make some kind of an arrangement
6 for a standard prescription form. There are hundreds of
7 different kinds of prescription forms available now.
8 I think it would be imperative that the medical profession
9 be asked that all prescriptions should be suitably
10 marked whether they are to be repeated or not repeated,
11 the intervals on which they are to be repeated and this
12 is one area we found that leads to a lot of problems,
13 and we would like to see some clarification on that
14 particular point. Now the standard prescription form,
15 if there were such a thing, may be the answer to it.
16 If we had, say, at the bottom of the --- bottom left
17 hand corner of the prescription pad a section which
18 would deal with this subject which I speak of on repeats
19 and the number of repeats and the intervals. If there
20 was some way of enforcing ,then you would probably have
21 the problem solved.
22 Another point which comes to mind along
23 the same lines, is that it is oftentimes hard for us to
24 make out a doctor's signature. I don't say this in a
25 derogatory sense, but I think the medical profession
26 have been known not to be the best writers in the world.
27 Maybe this doesn't only apply to this profession, but
28 I think this is sort of a standard comment that other
29 people make. And I am delighted when I see some doctors
30 who have a rubber stamp who stamp their names on the

1 pads. Some doctors use clean prescription pads with
2 no headings on them. Some use them printed with their
3 names printed on the top. But with just a plain ordinary
4 white sheet of paper with nothing on it and some
5 signature on the back which is not recognizable to us
6 makes it very difficult for us to identify the validity
7 of the prescription. If we had, for instance with a
8 rubber stamp, if the doctor was to stamp his name by
9 means of a rubber stamp and to include his registration
10 number all in one rubber stamp, I think this probably
11 would solve a lot of problems.
12 THE CHAIRMAN: Isn't there the danger
13 there,that of the unauthorized use of the rubber stamp?
14 MR. O'MARA: I think this could be but
15 it would have to be up to the medical profession. I
16 mean I have to keep my narcotics locked up. Why can't
17 a doctor keep his rubber stamp locked up?
18 DR. LEHMANN: You can have rubber stamps
19 made easily. You can't have narcotics made easily.
20 You can have the same kind of rubber stamp made.
21 Anyone can order it.
22 MR. O'MARA: I think with the doctor's
23 medical license number, as far as I know I don't think
24 this is common knowledge, I am sure it is only the
25 doctor who has his number.
26 THE CHAIRMAN: Well, we might have a
27 combination of the two things, a rubber stamp --- in
28 order to make the doctor's name legible and his
29 signature in order to attest himself ---
30 MR. O'MARA: Maybe there is some other

way apart from a rubber stamp. I just put the rubber stamp suggestion forward seeing some doctors that use the rubber stamp underneath their names. Now you for instance take an example of the number of doctors that have come into this province from outside of the province, who are not known to us --- I realize we do get a copy --- every pharmacist on the island gets a copy of the medical register to see if every doctor is registered under the Act. It is difficult to identify the doctor and if for instance you phone a hospital to identify a certain doctor, sometimes it takes you half an hour.

DR. LEHMANN: It is impossible because the other day I wrote in my own province, I wrote a prescription on my own printed prescription pad with my name, my address, my license number on it; I signed it; I myself went to the pharmacy to get what I had ordered and the pharmacist asked me, "could I tell him the license number," and I said, "No, I couldn't." So he looked at me very suspiciously and I said, "could I look on the prescription"and he looked at me very suspiciously to see if I had actually given him the prescription. It is in fact impossible to identify. I could have been an imposter of course. There is just no way of making sure.

MR. O'MARA: Then you can see the problem for us is then that much greater in trying to identify the legality of a prescription.

THE CHAIRMAN: Well, we are going far afield now. Why couldn't we have a book, a prescription book with your picture in it just like a passport book

in which a prescription is stamped, you have to present your book, it is noted, you avoid prescription shopping, you facilitate identification, I mean the passport identification is at the top, form of identification on which the law relies. You can't do much better than that, that I can think of. Why can't they have that? I mean if this matter has become so serious and so important as it seems to be, is it so much more trouble for all of us to carry a book if we need a lot of prescriptions ,to carry a book in which our prescriptions are noted, and our total amount of drugs is noted? I admit it is another inconvenience in life, but are we serious or aren't we? Are we serious or aren't we about this matter?

MR. O'MARA: Let's take it another step.

THE CHAIRMAN: Incidentally, I am addressing that question to both you and my colleague, Dr. Lehmann.

MR. O'MARA: Well let us take it a step further and look at the telephone prescriptions which is an altogether different problem in the same area, but which is far more complex than the business we are just talking about, the signatures. Now surely you realize that there are doctors, there are nine doctors in the building that I work in, and I know every one of their nine voices but I can't say that I can go any further than that. And this is becoming a big problem with telephone prescriptions and unfortunately I don't think the doctors are aware of how grave this situation is. And it is increasing all the time, they are tending

to let their secretaries phone in prescriptions which is the biggest problem of all.

DR. LEHMANN: You do not have to accept them. Why do you? Why don't you insist that they fill in whether it should be repeated or not? Just having it printed on the form wouldn't assure you that they will fill this out,but if the pharmacist will insist not to fill a prescription unless it is marked, may be repeated or may not be repeated,how often, why don't you insist?

MR. O'MARA: We do insist, or we try to insist that if the doctor has a repeat for one year and we say, "Doctor, look,this is not sufficient." As far as the law is concerned it does not cover. You want to say that you want it repeated every 30 days for three months and he says, "Well I wrote repeat for one year and as far as I am concerned, that is satisfactory."

DR. LEHMANN: He has to learn that that is not right.

MR. O'MARA: As I say,maybe it is a case of educating the medical profession and I don't blame them, maybe they are unaware of these rules and regulations.

Another thing which the doctors' considerable concern was, was the naming of prescriptions. This has been for many years. Many of them would like to have the naming of their prescriptions.

THE CHAIRMAN: What does that mean?

MR. O'MARA: Putting the name of the drug on the label. This of course is an indication that

the doctor wants the name of the drug and each individual name. There are a lot of medical associations who have supported this but we have been dead against it simply because once we are told to do something by the doctor, we have no alternative but to follow his instructions, the same as supplying the instructions. But we believe that there are other ways in which this could be done, apart from naming the prescription and by this I mean instituting some kind of national coding system for our drugs. There are one or two companies that have a makeshift coding system, but it is not a good system. But this would get over this problem of labelling drugs. This we believe is tending to put information into the public's hands which should not be in their hands.

THE CHAIRMAN: I do not understand, why are you opposed to it?

DR. LEHMANN: I can answer than. Take for instance a patient who had an attack of psychosis and the next three years he has to be on phenothyacins. He may be travelling into another province or country but he should know exactly not only what drug he has to take every day, but how much of it, and he has to be able to tell somebody in Britain or in France or wherever he is travelling what he needs, or the doctor from whom he will get the prescription, know what he was on and what he needs. He cannot go into France from the States and say, "I was on such a code number", and the doctor would not know what the code is unless he has it right with him. Now, there is every reason

for many patients to know what they are getting and how much they are getting. For many others, they should definitely not know what they are getting. I don't think many should know they are on amphetamines for instance, or for that reason barbiturates.

THE CHAIRMAN: Why, why? I do not follow that at all.

MR. CAMPBELL: I would not have a drug in the house unlabelled for the simple reason that once I do, then I think for the simple reason that I wanted to take codeine and my daughter takes stilvesterol and stilvesterol is not the drug I want to take.

THE CHAIRMAN: Dr. Lehmann, why should amphetamines not be labelled?

DR. LEHMANN: I think that if the doctor prescribes an amphetamine for a week or so and he maybe have a neurotic depression and he wants to see if it will work, and it may work, most doctors would not want these patients to know they are more addiction prone than others, because they are neurotic, what they are on, because it makes them feel good, so they may later want to get that very same drug from some other physician just because it made them feel better. They should not know what it is.

THE CHAIRMAN: I see.

DR. BHATTACHARIA: I think Dr. Lehmann knows one of the points,that we doctors still treat our patients as if they are nincompoops, and give them drugs without telling them the side effects, the consequences, and so on and so forth. I think you just have

1 to read a woman's journal, all the drugs and its effects
2 are written. Who are we hiding it from? I think if
3 you are doing the research, double blind trial, I am
4 all the way with you. But when there is an established
5 drug, an established patient will have to take it. I
6 think he has every right to know about that drug the
7 same as diabetics must know about insulin.
8 DR. LEHMANN: That is different. Diabetics
9 do not have immediate present effects from his drug.
10 Another effect might encourage a person.
11 DR. BHATTACHARYA: Well when you say
12 pleasant effect, those drugs are very few.
13 DR. LEHMANN: Very few.
14 DR. BHATTACHARIA: I think dexedrine
15 amphetamine might come to that extent and if that is
16 so, I think you should tell the patient that it might
17 give you a sense of euphoria, so don't at that particular
18 time try to date your secretary. Point out all these
19 things. I think we treat our patients in a particular
20 way. We just don't want them to know they are on drugs.
21 And I have many patients who have taken drugs and they
22 were not explained, or told,and especially with anti-
23 depressants,and they get extremely nervous and worried.
24 DR. LEHMANN: I would think about every
25 drug with few exceptions. That is my own judgment.
26 DR. BHATTACHARIA: Very few.
27 MR. CAMPBELL: Let us get back to the
28 questions I raised with the pharmacist.
29 DR. LEHMANN: Excuse me, why are the
30 pharmacists opposed to labelling?

1 MR. O'MARA: Well I don't think I agree
2 --- I agree with Dr. Lehmann, there are certain drugs
3 which definitely shouldn't be identified. I can give
4 you an example. Recently here in this city we had a
5 parent who was on some amphetamine, I don't know which,
6 maybe escotron and it was labelled and in the father's
7 medicine cabinet. A teenager took the container to a
8 pharmacy, the prescription was quite legitimate, it was
9 a prescription which was allowed to be repeated, marked
10 to be repeated, and it was repeated and they fell into
11 the hands of the teenager. Now I think this points out
12 what the Doctor has just mentioned there, that there are
13 some drugs which you certainly would not want to have
14 labelled.
15 DR. BHATTACHARIA: But you have the
16 opposite story as well. You have given the drug. I am
17 one of those who has rubber stamps, but if you have
18 given the drug and you do not tell the patient what
19 the name of the drug is, what effects it might have,
20 and you may find the child has taken it. They have not
21 taken the safety precaution. The opposite story the
22 other day, that of a child that took some of the drugs
23 that were given and the mother said, "I was not aware
24 that they were like that." I think right of the knowledge
25 is your prerogative, because the prescription does not
26 order the patient to take the drugs. That sign does not
27 mean you must, it means"would you please." And I think
28 if you are making a contract of that sort, medical ethics
29 has to support it I think we should ask our patient
30 "would you take this drug."

1 MR. O'MARA: I think that is possibly
2 true if the doctors were prepared to give it to the
3 patient. It is the pharmacist 80% of the time who
4 wind up giving this information, and I think it should
5 be based on medical profession.
6 DR. BHATTACHARIA: I agree with that,
7 and that is why I have said a long time, many times,
8 it is the doctor's right.
9 MR. O'MARA: Well if we could have it
10 one way or the other we would be happy but it is
11 completely out of our field altogether.
12 MR. CAMPBELL: How do you explain what
13 I have raised? I mention the stilvesterol and the
14 codeine. I just took a pill out of my briefcase. One
15 of the pills I have is niacinamide and codeine and
16 this is silvesterol, and in a house of four kids and
17 seven cats and bunch of fish, I have some algae killer
18 capsules that looks like some other things for humans
19 in capsules. How is the responsible person in the
20 house with all sorts of these things able to
21 identify what that is? If they are found in the house,
22 there is a very significant risk of the danger of non-
23 medical drug use. With a lot of children and pets you
24 end up with a lot of bottles and pills.
25 MR. O'MARA: If a doctor would prescribe
26 an antibiotic, one four times a day for three days,
27 there are a vast number of some people, where the
28 doctors do not relate this information to the patient in
29 a lot of cases. That patient should take the complete
30

three day treatment, not leave two or three over for the next time when he has the same ailment. That prescription might hang on in his bathroom cupboard for a year before he starts taking it, then when he gets the symptom he has had before, he decides he will take three more.

MR. CAMPBELL: But in a normal household it would not be unreasonable to have niacinamide. It would not be unreasonable to find half a dozen 4 grain codeine.

MR. O'MARA: I would not say that it is reasonable,sir.

MR. CAMPBELL: Why not?

MR. O'MARA: I just don't think that to have 4 grain codeine around your house would be reasonable. Maybe you should direct that question to someone in the medical profession.

DR. LEHMANN: I would agree with that.

MR. O'MARA: Who would probably say that I am sure --- if that is the case I personally would say it is indiscriminate prescribing, because codeine is too dangerous to be left around like that.

DR. LEHMANN: Well I would think aspirin would do as well ---

MR. CAMPBELL: If it is an abcess it won't.

MR. O'MARA: I think this is just getting back to the drugs I have had and there is another dangerous thing, particularly with small children around, that there should not be large quantities of

1 drugs around in anybody's medicine cabinet. Drugs are
2 prescribed in the course of treatment as specified.
3 Once the course is taken, the course of treatment, they
4 are gone and that is probably the end of the course of
5 treatment, not to have them as you find them in many
6 medicine cabinets, two, three, four, five, six left
7 out of a dozen which is not a course of treatment at all.
8 And this I think is a very, very dangerous situation.
9 I recently spoke to a doctor who told me he had gone
10 into a home to visit a patient, and when he diagnosed
11 what the ailment was, apparently it was nothing serious,
12 and his answer was "well, do you have a few 222's," and
13 she said, "well just a minute, Doctor," and she went to
14 her bathroom cupboard, and he said she had at least
15 two dozen containers of tablets.
16 THE CHAIRMAN: Of tablets?
17 MR. O'MARA: Of different kinds. Which
18 is completely unnecessary, because the courses of
19 treatment for which these had been prescribed for were
20 not carried out. If it was a five day treatment, the
21 patient had only taken it for three days, decided to
22 give it up and left it.
23 DR. BHATTACHARIA: I think this is due
24 to the advertising of the drug. You just turn on your
25 television and the drug companies are pouring out
26 information. Phenothyacin is a drug which I think is
27 dangerous and it will be withdrawn in the near future,
28 but just look at the way that the hand comes in with your
29 headache, and the iron pills, the kidney pills.
30 MR. O'MARA: You are not talking about

prescription pills.

DR. BHATTACHARYA: Yes, this is why they are stocked in the house because the television ---

MR. O'MARA: I was not talking about propriety made, I was speaking of prescription categories.

THE CHAIRMAN: You were mentioning, Mr. O'Mara, that there were four points and I got three of them, and I wondered if the labelling was the fourth? Was that the fourth matter you were dealing with? You were dealing with recommendations of our report.

MR. O'MARA: Three.

THE CHAIRMAN: Three.

MR. O'MARA: I think the point was we were in agreement with your position, but there were some areas where we want a bit of a stronger emphasis.

THE CHAIRMAN: Excuse me, does that conclude your presentation?

MR. O'MARA: Yes.

THE CHAIRMAN: Are there any questions or observations from the Newfoundland Pharmaceutical Association?

DR. LEHMANN: May I just ask a question, something that was repeatedly brought up to us by the pharmacists, whereby the Pharamaceutical Association, and that is referring to the question I asked you: why not tell the doctor that he must mark whether it ought to be repeated or not? Frequently pharmacists have told us, well, they don't like to do this because doctors get quite nasty, and they say, "Don't bother me, you know perfectly well what I mean and leave me alone,

1 I have other things to do." And telling them that their
2 secretary must phone in the prescription and then the
3 doctor again would then say, "Well, this is fussy and
4 tacky, and why don't you just fill out the prescription."
5 And that is that. Is that an important reason why
6 pharmacists would hesitate to draw the doctor's
7 attention to the fact that they are not fulfilling the
8 requirements of the law?
9 MR. O'MARA: Yes, I would say that would
10 be basically --- I think that all of the problem could
11 be --- I know there is a certain onus on the pharmacists,
12 but I think this whole problem could be overcome if the
13 doctors would obey the law and if they were required to
14 put it on a prescription;instead of "repeat",if they
15 were required,as in the case of a controlled drug,to
16 mark down it is to be repeated every 30 days three times
17 ---
18 DR. LEHMANN: I think they are required
19 to do this. They just don't do this. Someone ought to
20 either refuse to fill the prescription or tell them they
21 have to modify it. And my question is, why would not
22 pharmacists do this, or hesitate to do it?
23 MR. O'MARA: I don't really know, I can't
24 answer that question. For instance, in my own case, in
25 cases of my own I have said to the doctor,"you have
26 this prescription marked to be repeated, that's not
27 legal. You have to tell me how often it is to be
28 repeated and at what intervals"and 99.9% of the times
29 the answer you always get is, "I have it marked for one
30 year and that's what I want, repeated for one year."

DR. LEHMANN: It means education of the medical profession.

MR. O'MARA: Yes.

THE CHAIRMAN: Thank you very much, gentlemen.

I call now on Father Holland.

FATHER HOLLAND: Thank you very much, Dean LeDain. I wonder if I may call on some people to support me. I have four friends of mine here present and if it is all right with the panel?

THE CHAIRMAN: Yes.

FATHER HOLLAND: I always get tempted when I see such an apt group like this to give a sermon. Instead of that I thought of taking up a collection, and I feared the results might not be profitable. Then I thought of organizing a bingo game and I didn't bring any cards with me.

So instead of that, I am going to make the report. The background on the report is of some interest. I am taking up the "A" section of your terms of reference, and I would like to give you some facts and information, as much as we can give you facts and information.

THE CHAIRMAN: Which section is that of the terms of reference?

FATHER HOLLAND: "A", is it not?

THE CHAIRMAN: "A", the terms and effects, the general picture.

FATHER HOLLAND: It is "A" and I would like to fill in the general area as well as some of our

1 own. I would like to thank you for the opportunity to
2 come up here, and I would also like to thank the
3 Executive Secretary for the interim report. Everyone
4 represents some body, and if I may use the expression,
5 I represent myself. I have proposed to the high schools
6 in the city that there was an opportunity to get to
7 the Federal Government through the LeDain Report, to the peop
8 and they were rather eager to make their report and
9 insistent that we should go about it. But I will give
10 you some of the facts and figures in a moment. There
11 may be questions from the floor, or from the Commission
12 at any particular time.
13 There are 461 people involved in a
14 questionnaire. It is a survey kind of report, and it
15 is not a research report in any way at all. The survey,
16 I think was answered in a very serious way, at least
17 it is reported it was. If anything, the report lies on
18 the side of the user, not saying he was a user, so you
19 might estimate it much more stronger than the figures
20 that I shall give. However, I am reporting on exactly
21 the information I received; no more, no less. Out of
22 461 people who were asked to fill in a questionnaire,
23 71 reported that they had contact and experimentation
24 with drugs, that is, 14%. I rounded off all the percents
25 here. It is actually 14.5%. I have divided my report
26 into three parts: non users; view of them; the users;
27 and then I have made some ideas that you have to draw
28 from the statistics that you arrive at.
29 86% reported that they have not experimented
30

with drugs in any way at all. However, of the 86% who reported this, 46% said they had no knowledge of drug users and no particular knowledge in their own circle of friends.

THE CHAIRMAN: Excuse me, the way mine reads here, that 46% had knowledge of drug users who were not in their circle; is that right?

FATHER HOLLAND: Yes. That is right. I want to make a point here, 46% had a knowledge of drug users, but not in their immediate friends. And there was another group, 31% who were just simply ignorant either of knowledge of drugs or friends. That leaves a rather high figure of about 75% who neither have direct contact with drugs nor direct contact with those who have drugs. That is a fairly high number.

Some of the ones claimed that there are about 25% who have knowledge of drugs either through their friends, either in the school or outside of the school and I have broken that down, but the figure is not important.

A small number of the group who were non users, only 22% said that they would like a drop in centre but that is what you would expect in this area, because we have had no knowledge of a drop in centre and I even feel the word was not familiar with the people who responded to the questionnaire.

A larger number, almost three out of four of a group of non users,said they wanted and would like information for an education programme on drugs. Only two said they would like to see a student council.

MR. CAMPBELL: Only two ---

FATHER HOLLAND: Only two. 40% said they knew drug pushers and I will be coming back to that figure in a moment. Now I am going to take up the second part of the presentation, the user.

The drug most often used in the St. John's area,if this report is representative,is that 85% used marijuana and I included marijuana as being grass, hash and so on.

DR. LEHMANN: 87% of those and 14% who do use it?

FATHER HOLLAND: Yes. And then we had some question this morning about the use of speed in the area. This report would indicate that speed is used much more widely than Dr. Boddie indicated. This would indicate 23% had experimented at some time or another and used speed. All of the other drugs, MDA and so on, were about 10% had used it. Another interesting fact was that 18% of the drug users had experimented with more than two drugs. I find that figure rather high but this is what the report says.

MR. CAMPBELL: Would this be more than two drugs, Father, in the sense that on the questionnaire you have got: marijuana, pot, hash, hashish. Now if a person had circled marijuana, pot and hash, would they be in the 18%?

FATHER HOLLAND: No. This was two distinct kind of drugs as we have them listed.

There was a consistent pattern of drug usage ;that about 43% started off with marijuana and then

1 continued with it, although a few started off with--- 14%
2 with LSD, and changed over to marijuana. The survey was
3 rather weak on this particular point as we discovered
4 later, but this is what we drew from it.
5 I am going to read this because it is
6 kind of important: the survey indicates that the drug
7 usage is growing rapidly. While the majority, that is
8 50%,is more than 50, first started using drugs by the
9 end of June, 1970, 25% said that they began to use drugs
10 during the summer and an incredible number, 25% indicated
11 they started using drugs in either September or October
12 of this year. That was six weeks after we started school.
13 The survey was given on October 12th. If I could
14 interject something that I found in the brief, I believe
15 it was 1969,and Dr. Pottle is aware of this, and when
16 the Department of Education and Department of Health
17 polled the schools and asked if we knew any incidence
18 of drugs or had any information about drug taking in
19 St. John's,and they asked a cross section of high
20 school personnel including students, and the response
21 was almost unanimously "no". By Christmas it had hit
22 us.
23 However, if I can mitigate my figures
24 somewhat, about 36% have experimented only once, and
25 normally this was with marijuana, though not always.
26 However, there are regular users. 26% of those who
27 indicated that they had used drugs say that they take
28 it once a month and 14% say they take at least once a
29 week. We asked the group the reasons for taking marijuana.
30 Incidentally, the way we set up the test, we went to the

1 students and asked them to put it in proper English for
2 us, because this is a different kind of culture so our
3 words are not the words that are used by people who are
4 involved in this. So it was a pre-test that really got
5 the test and the language and information that was
6 discernible or perceptible by the student body.
7 The reason for taking drugs, the next
8 36% say they take drugs for reason of experimentation or
9 curiosity, and there were personal problems and hang ups.
10 26% kicks; pleasure, 25%. And as you suspect, most of
11 the drug users or almost three quarters of them knew who
12 the pushers were.
13 Observations: third part.
14 While the percent of drug usage is high,
15 14%, there was a correspondingly large number of non
16 users and that was about as I indicated, 75%. It is
17 actually 77%, who are not in personal contact with
18 people taking drugs or who have very little knowledge of
19 drugs. And that may account for the lack of real
20 interest in a drug education programme throughout the
21 whole survey.
22 The users on the other hand want informa-
23 tion and they urgently seek the drop in centre, especially
24 those who have used on a regular basis a variety of
25 drugs. Moreover, this group of drug users were very
26 interested in getting contact with somebody who had
27 some knowledge of drugs and this could be in a student
28 council. They also wanted direct information, the drug
29 users wanted information and the remarks on it indicate
30 who they were on the report, was "we want it straight,

we want the facts," over and over again. Interestingly statistics seem to support the validity of the survey and I think it indicated that the survey was a truthful survey at least in the facts that we are presenting, and I don't want to get into that, and I think Dean LeDain has it if the Commissioners wish to look at it. There are two other conclusions: that the drug users know the pusher is understandable, that the non users know the pusher, and there is 40% of them, is not as understandable. It is evidence of something and something that we are not aware of that there is a whole culture and subterranean communication system at work here. And the adults get out of this and the teenager is aware of it, and we were very much aware of it, and I suspect the members of the Commission are too. If the survey is accurate, then it indicates a most disturbing trend and that is that drug usage is increasing at an alarming rate. The facts in the survey are mitigated somewhat by a deep analysis, for instance, 50% of those using drugs for the first time say since September of this year have experimented once and only once,have taken a marijuana cigarette. Yet the fact is there, more teenagers are using drugs and they are doing this persistently. Not found in the report that Dean LeDain has, I am a bachelor and a politician, I have to do my own laundry, and the last time I did it everything came out blue. I had put a blue something or other in there. I am not a publisher of the laundry problems, and I am not going to the LeDain Commission for response to my problems in this matter but everything is

coming out drugs, isn't it? And Dr. Bhattacharia, I think, has told us that everything should not come out drugs. We have a problem and we label it as part of the drug problem, and I think the drug problem has to be put into a context and into a much larger context. If we make several pleas, and it is really a plea of St. John's community, we need a drop in centre and we need it urgently. We need it urgently. When you are dealing with young people, where do you send them, where do they go? We could send them to the general hospital, and that is the only place, or to a psychiatrist. We have no in between place. We need it and we need it badly.

We also need a drug education programme and I have listed several people who need to be included for the drug education programme. Teenagers, I pass over that because it is obvious. Teachers who are uptight, parents. We heard the most eloquent views this morning from the parent who was most fearful and we need to answer that fear. I also submit that the medical can do with updating in the in-service programme on this fact. At our meeting, a drug conference we had last spring, it was suggested that it would not be a bad idea to also educate the news media in drugs. What is the attitude on drugs? I speak only generally. First of all it is sharp curiosity, interest. I detect now, apathy. I feel apathy and if I can measure it correctly, the response to the LeDain Commission, I hear apathy too. I hear apathy from students who now are turned off of the drug programme. We have gone through the course of drugs now. I know students who now have made their

decision on drugs. They are not going to have drugs. They have put it out of their lives, and I think Dr. Bhattachar a was saying just that problem. They have a system of drugs. I have students coming back now who want to help other students and that is in St. John's because they know what the problems are. We could very well do with a crisis intervention centre. I know one student councillor who has had to talk down drug users. I do not think that is quite our job. We shouldn't really have to go around with a package full of downers.

That is everything. Thank you very much.

THE CHAIRMAN: Thank you, Father. Are there any questions? I would like to ask a question about these figures of increase. Do you have any distribution by age --- what are the ages roughly in grades 9, 10 and 11?

FATHER HOLLAND: It spans from 14 to 20. I would say largely 15, 16 and 17 ---

THE CHAIRMAN: They just would be 15, 16 and 17. Right. Now do you have any sense of at what age the use of marijuana is beginning as in that span?

FATHER HOLLAND: No, none from this survey, but do you want me to ask one of my students to reply to that?

THE CHAIRMAN: Yes, what I really want the sense of is the significance to be attributed to this 50% who began. Where are the 50% who began since summer? Where are they in that age span? Have you any

sense of that?

FATHER HOLLAND: Naturally, but I suspect it is the younger group, the younger teenagers. They would experiment and have available the marijuana.

DR. BHATTACHARIA: You said 461. How many replies did you get?

FATHER HOLLAND: From 461 out of a school population of 533.

DR. BHATTACHARIA: Did you send it to all 500?

FATHER HOLLAND: I gave it to 461.

DR. BHATTACHARIA: Were they identified?

FATHER HOLLAND: Not in any way whatsoever. I asked only those who were present to turn it in. Some who were not present on the day we made the survey came to me later and asked for the forms because they wanted the report to come out in public.

MR. CAMPBELL: Father, were all the students in attendance on that particular day?

FATHER HOLLAND: On that particular day.

MR. CAMPBELL: And that day was in the term of the middle of October, 1970?

FATHER HOLLAND: Yes.

MISS BERTRAND: Did you say who distributed the questionnaire?

FATHER HOLLAND: Yes, we distributed the questionnaire by classes and under circumstances where there was a kind of a relaxed atmosphere, and where the questionnaire would be answered favourably.

MISS BERTRAND: "We "meaning the teachers?

FATHER HOLLAND: The teachers. We had prepared the teachers for this.

MR. CAMPBELL: But the student could feel assured that the teacher would not identify him?

FATHER HOLLAND: Yes.

Do you want to hear the remarks?

MR. HENLEY: I want to make one remark on what Father Holland said there. There were 30 teenagers who had possession of marijuana, and there were stimulants and such things. I do not think it can be broken down to a certain age group, because in the teenage society today there are so many teenagers that they do not go around and say it is 16. I think it is more the circumstance of the environment in the city, and I would not say that an age has anything to do with it, or that a teenager of a certain age would have more possibility of being in contact with drugs than that of another age.

THE CHAIRMAN: You would not feel it would be a fairly equal distribution between the grades 9, 10 and 11, would you?

MR. HENLEY: Yes, especially in high schools.Because most are in contact with those and in that area there is not the big percentage of students like possibly --- most know the students, and there is not the generation gap of parents and students as there is from grade 11.

THE CHAIRMAN: All right, where do you feel is the important dividing line in grades? Where is the important starting point?

MR. HENLEY: I would say the important starting point of use would be when the person buys it.

THE CHAIRMAN: I am sorry, I mean at which age and which grade roughly does the start of use become significant?

MR. HENLEY: It would be easier to say that when the person has the effects and you could talk to that person. A 13 year old could realize what effects it could have, and a 13 year old could realize what it was and I think he would be more interested in taking it than a 16 year old who did not know what effects.

MISS BERTRAND: Did you say that the study was done in St. John's,Newfoundland?

FATHER HOLLAND: Yes.

MISS BERTRAND: I am afraid it is not a very fair question to ask, but what would be your estimate of drug use outside the city?

FATHER HOLLAND: I would suspect it is much higher than the population outside of St. John's would recognize or be willing to admit. There was a youth --- one of our local papers did a survey again in St. John's and they estimated that I believe it was 5% to 7% at that time, that was last spring. There are areas in the province where drugs are readily available and certainly are used. I know one member of Parliament here who represents one of the St. Anthony's --- up in the northern part --- and he is hearing about drug usage from his riding. He happens to be the Minister of Health.

MR. CAMPBELL: I am sorry, I have forgotten your name.

MR. HENLEY: Mine is Steve Henley.

MR. CAMPBELL: I wonder if you could go into statistics as to why people take drugs. Could you expand a little bit of how rapid the course of drugs is in school or how it fits into a social school use.

MR. HENLEY: I could first start off by acceptance. A lot of students want to be accepted into certain little groups of people who they like to be associated with and on a lower scale. Say if friends--- like, if your friends like sports and if you want to associate with those friends and you think they are pretty good kids, you will like sports too. I will give you an example of why kids want to take drugs. If you see people you have known and you think they are pretty nice guys and you go out with them and they start taking drugs, well then you say,"well if they are taking them I would have the same acceptance as they have." So that could be one reason. Another reason could be that many teenagers today --- I remember about seven or eight months ago the press was really having a good time in the sense of it being censored, and so they say there must be something wrong with it. So that could be the two main reasons I think, just rejection of moral standards in societies or just an acceptance into the teenage society.

MR. CAMPBELL: In this society where cannabis use prevails, what would be the pattern of this use? Would this be a weekend phenomena or would drugs be used steadily after school each day?

MR. HENLEY: I would say mostly on a

weekend because I think most people who do drugs have contacts in schools, and the students usually get their allowances on weekends. So I think a lot of plans are made for such weekends and that is when it would happen.

MR. CAMPBELL: And the weekend use would then be, I gather, purely social?

MR. HENLEY: Yes, and also in such communities there is a lack of things to do and a lot of people would rather do things by themselves so they want to just be in their own little world rather than going out in crowds hardly doing anything. I remember last year the Government put out the youth commission of St. John's and they asked us questions, they wanted to know what we wanted ,such as drop in centres and so forth, but if there was such places there would not be --- a lot of people today want to be individuals, get out by themselves rather than do things in groups. And they would be by themselves ,and if you want to say ,groove by themselves, they would turn on with drugs. So a lot of them would groove by themselves rather than just go off and do nothing with other people. It is kind of a singular thing to be by yourself. Mostly you need a few people to do something but this is something you can do by yourself.

FATHER HOLLAND: Could I come to develop that? Over the weekends in St. John's we have bad vibrations here. There is not much for our teenagers to do, and as a consequence, and there was a lady here this morning talking about the rock festival, and when you turn the music off, you know, and I am going to

finish that --- over the summer those of us who were interested in the drug problem predicted that the curve will increase greatly because I don't know what a teenager does over the summer in St. John's. He can't find a job if I may identify myself as a teenager. There is very little to do, very little community activity or recreational activities and what do you do? The drug problem could very well be a city or a community problem as well as just a drug problem. We are attacking it solely as a problem head on, and I think that the education programme could very well be part of it, but it is only one element of it.

MR. STEIN: Do you talk to the kids around school in pretty general terms about drugs? What sort of things are on their mind?

MR. HENLEY: In the high schools today there is sort of like a lack in the community and students are so fed up with papers blasted at them, people not telling things to them but telling things at them and a lot of them are forced to accept values that they won't accept, because I could say St. John's is not one of the most forward communities of Canada and a lot of the moral standards in St. John's are quite backward from a lot of other communities in Canada, but then again the headlines come from all of the other communities, and they can't accept such headlines under the terms in which they are living today.

MR. CAMPBELL: What are the values of St. John's that are most unacceptable with kids?

MR. HENLEY: I would say drugs is one.

1 Really that is the biggest one of all because students
2 are really fed up with hearing about them. It has really
3 been blown wide scale for the past twelve months and
4 everywhere you look you find something on it or somebody
5 talking about it. It is a big thing to discuss; it is
6 more of the --- it takes up most of the grapevine of
7 a student body you could say. That is the big word
8 today. Like who is bringing it in, when it is coming
9 in, stuff like that. That is what is talked about. A
10 lot of students talk about unity, like on the grapevine
11 for one you could say Woodstock was the big head because
12 such a group of people gathered together for a good time
13 they say. And when a student realizes such times and
14 such things they could accept, they will talk about it.
15 But I remember in school today and I
16 remember for the past two years, essays were given out
17 on topics and a lot of people referred to the old topics
18 such as the war in Viet Nam and a lot of these are
19 drawn so far out that they are not of concern any more.
20 So students today just want to "cop-out" I could say,
21 you know.
22 MR. CAMPBELL: What about when they
23 look at the lives the parents live or the values that
24 dominate their parent's lives? What are the things
25 about those parent's lives they don't want to see
26 happening in their own?
27 MR. HENLEY: I think I could say material-
28 istic values. A lot of parents are dominated by their
29 pay cheques, mortgage on their houses and bills for
30 their car and so forth, which is a part of life, but

they think all their parents are living for is just to get up with the Joneses you could say, the old cliche, that is what is really getting to the teenagers sometime, and a lot of parents want to dominate the teenager's lives. They want you to do what they want to do, what they wanted to do then when they were teenagers, and a lot of parents don't accept there has been a lot of changes in the world since the '20's or '30's and so they think that we should accept what they accept when they were teenagers. And their values of life are put so much on materialism that it is really bad. That's what a lot of teenagers consider.

MR. CAMPBELL: Where would the teenager lay his values?

MR. HENLEY: I would say unity between everybody. Let's say more of a Utopian society they would like rather than materialistic values, a freer state of affairs. Like everybody is so cramped up now that they don't have time to do what they would like to do and they would rather have people living the lives as they think they should live them rather than living their lives the way other people think you should live them.

MR. CAMPBELL: When you look at the school system, what are the predominant values that are reflected in the schools?

MR. HENLEY: In the schools, the most predominant value is education right now. They want you to get your B.A. or your Masters so you will be accepted in society, so you will be able to get a job

and so you will be able to work and support a family. In Newfoundland we have Government exams, which rule the whole province. I would take the same exam as a person would, say, in another part of the province who would have maybe a lesser or greater degree of education than I would have, and thus everything is based on how much education you could have, and even in class today if the teacher says something, tell you to learn an essay, well it could be on the exam,and that unnerves a lot of students; that it seems they are only studying for exams and only studying for a degree, so that they can work. They don't seem to realize that they are studying for themselves and their own self education.

MR. CAMPBELL: Kids who are aware to sort of look at the broad way of existence, does it make any sense?

MR.HENLEY: In what terms do you mean "existence"?

MR. CAMPBELL: The way people see life itself, being alive in general I suppose, the order of existence.

MR. HENLEY: I think kids today realize that the world is just a cycle of people who don't know what they are doing. You can take a walk downtown some day and all you will see is people going from one place to another doing something that they don't have any direction of doing, and teenagers just look back and some laugh at it. Others want to drop out of it and others just don't want to go into it. So teenagers with the existence would rather see them doing what

their own lives say they should do, what they think they should do rather than say that they should live in a cycle or a pattern which is going to be unchanged for approximately, say, 40 years. Because when you get a degree and so forth you get a nice stable job and it is the same ground for the rest of your life and I don't think teenagers can accept that.

MR. CAMPBELL: Did you know of any feelings of where the whole thing is going?

MR HENLEY: They just think it is all going down the drain.

MR. CAMPBELL: Life and society, does it bother them?

MR. HENLEY: It doesn't bother them because they know they can't get out of it. A lot of people won't listen to teenagers because they are only teenagers; because if you looked at a teenager and you say,"well, I am 45 years of age or 50 years of age, and what has he to tell me, he is only 17 Who is he to tell me what he knows? Do I even have to accept or even listen to his suggestions." They just bracket people as teenagers today. That is what really unnerves a lot of teenagers, that they are just being a burden on society.

DR. LEHMANN: Didn't they always do this? You said today.

MR. HENLEY: I wouldn't say they always did because a lot of time when a teenager and a parent have their own interests which are the same, they could enjoy those interests and they could even talk

in those interests. But a lot of parents today are so set with the problems of the world which are around them, they think that their judgment is just for them, and also just for their own children.

THE CHAIRMAN: Is it possible though that teenagers have also maybe set themselves apart from parents? I mean do you think ---

MR. HENLEY: It is also possible, and it is true too. If you put a teenager and a parent together and that one teenager looks at them and says, "Which one would you like to talk to, the teenager would say the other teenager, which is quite normal. But I think just because parents today and the older generation today either, teenagers can't accept their education also. It is a two way affair I could say. It is both people's fault and I don't think either one are going around finding any of their problems by themselves. If a teenager gets in an argument with the parent, that teenager wants himself to be right so in the future the parent will listen to him. And the parent is going to want the parent to be right so that in future the teenager will listen to the parent. So they are both at each others heads in a way. You know, they both want to get at each other and they won't settle for a compromise, they both want to either succeed or fail and that is one of the major problems.

DR. LEHMANN: So you feel that the compromise is important instead of going out for all or nothing, that one would have to stop both, the older people and teenagers would have to accept a compromise?

MR. HENLEY: One point the teenagers look at is the legalization of marijuana. They would say it should be legalized and parents should say it shouldn't. Either one find hard to accept maybe there is a compromise in the middle; that a lowering in terms of sentences; let's say a sentence for people who traffic it rather than a sentence for persons to use it. A lot of teenagers,we say we would want this and we won't settle for anything else. A lot of parents would say, "I think we have the knowledge to say that we don't want it. They are our children and there is no dice."

MR. CAMPBELL: Let's look at Canada or look at Newfoundland. Do they feel that this is a society that is going down the drain perhaps, but nevertheless is a society where there is a reasonable chance of making a good life, is there a reasonable chance that they feel they could have the life they want in this society?

MR. HENLEY: It depends on each person's definition of a good life. Like in Newfoundland, it is sort of an untouched civilization, some parts of it. There is no society bracket. Like in St. John's there is a society bracket between people who live in certain sections of town and some suburbs. Out there everybody knows everybody else, they enjoy their lives, and they know what they are living for. But when you get masses of people together with such different education, they will not all settle for a compromise and they all think that each should be able to live on their own rather than associate with other classes of people.

MR. CAMPBELL: Do the people in the outer parts agree with this?

MR. HENLEY: I think they would, yes.

THE CHAIRMAN: Why do you think it is going down the drain?

MR. HENLEY: Why do I think society is going down the drain? I think it is because,one, the world is physically going down the drain. Two, people today are of such different nationalities, such different educations, cannot accept each other. Three, a lot of people would like to see themselves where they want to be and they shall be there if they cannot be there by any other means. If they want to be accepted by other classes of society, a low class will try to be accepted by a middle class merchant, he will have to get there by any means that fits. This is the white collar type which has now been shown, and I think society today has a chance of succeeding in general if people would get together and work out things in terms of a whole compromise. If you take a look at the United States and Russia today you will see how the terms of the countries are getting worse and worse all the time. Imagine if all the countries today were in a brotherhood which was useful. People might say United Nations is useful but it is actually there as a symbol. It is hardly useful any more. A lot of countries have the power to veto and if one country vetoes it cannot go through. There is just no doubt. So I think people who really try to help the physical state of the world and they really try to help the mental state of the world,

then society would succeed. That is quite a stiff order I would think.

THE CHAIRMAN: So you feel it is something in our attitudes and the quality of our personal relationships rather than something beyond our control, that is to say,some physical factors or other factors beyond our control that would doom us?

MR. HENLEY: I would say it is all in our attitude. I could accept you right now with you sitting up there and me sitting down here, or I could just stand up and walk out of the room. It is my attitude that makes me act as I do, or it could be a psychological state of mind which could be helped by a psychiatrist or psychologist which teenagers today find a help in, where they could speak to people and talk to people. But I think there is a lot of the older people in the world who do have a lot of major decisions --- I will make an example. If you take a look, if you were a rich man, he does not have any friends, does he? He is so dominated by his wealth, he is so dominated by what happens if something of his is stolen, if the press gives backing which it does, his attitude is really changed towards life. And if people today could really work out what they believe, take a good look at themselves, and ask themselves what are they doing, what are they living for, I think there would be a good chance to have a good society to live in. But that is one thing about teenagers, they try to look at themselves, they say "what am I here for?" Maybe it is not new, but I think that a lot of people who are in such a cycle of business and

1 cultures have a chance to take a good look at themselves
2 and say"Well what are you really doing?"
3 MISS BERTRAND: Would you say that all
4 teenagers really try to look at themselves?
5 MR. HENLEY: I would not say all of them,
6 but I would say a percentage of the ones who really
7 want to help society or help other teenagers, they do.
8 FATHER HOLLAND: If I could interrupt,
9 I feel like somebody who took Elizabeth Taylor to a
10 dance. Everybody looks at Elizabeth Taylor. And I am
11 delighted by this because I was hoping to have the
12 Commission meet a real flesh and blood teenager. It
13 was extraordinary in our survey the credibility that
14 the teenagers have placed in this initiative, the five
15 people. I think in Montreal we told the teenagers that
16 we put a lot of trust in you and I speak for a lot of
17 teenagers around here that we put a lot of credibility
18 in you, you bring a message back to where it will
19 hopefully be heard. We talked about values and Mr.
20 Campbell asked about values. To begin with I teach
21 religion and I asked these students what they wanted
22 me to teach this year and I was expecting God and the
23 Trinity, you know. No way. We filled the blackboard
24 with just about everything except something which I
25 thought had a theological base. I don't know if you
26 hear the message that I heard. I also hear a great
27 deal of pessimism from the young people and from the
28 older too. We are driving in a car that has a slow
29 leak in four tires, and there is no way we can take
30 that away from our teenagers. They just feel this, they

know it, they believe it. And someone mentioned this morning that it is an explosive world, it is a world of change. We have no way --- teaching ourselves or our young people to live with change. We have computers that guide and direct other computers. We are back to the philosophy again. Dr. Bhattacharia said it is a philosophical expression and until we face it, then the drug problem will not be put in its proper expression.

MR. CAMPBELL: Do you find difficulty in seeing the theological base in these things?

FATHER HOLLAND: No, because I happen to believe that theology needs to change too.

THE PUBLIC: Father Holland, I am a teacher here at the St. John's School, and I would like to reiterate some of the points of the young gentleman. I deal with quite a number of students and I can tell you that getting the rate of reaction of the students, they are literally turned off and fed up with the hypocrisies that are going on. I have asked a number of students what was the problem. And as Father Holland brought out in his brief, it is not an isolated drug problem, it is social and economic problems which are contingent to this thing. It is not strictly isolated drug problems. Kids have mentioned that they cannot see the isolated problems of society, the drinking, the smoking, the businessman who out goods his fellow human being, the slum landlord who has 10 or 15 in a flat. And I think the teenager here in St. John's is no different from the teenager in Montreal or Vancouver or any sophisticated North American city. They are

1 strictly the same, but most of the teenagers we have
2 today in St. John's are coming out loud and clear,
3 that their parents accept an Anglo-Saxon puritanical
4 view of society with the almighty dollar and surrealistic
5 values supercede everything else, and this is where
6 you have the conflict. This philosophical point with
7 the young people for example who want to be themselves,
8 they do not want to be pushed into the values of the
9 parents, and I think the young people have told me the
10 same,as these people are filled with idealism and to a
11 degree are filled with idealism.
12 DR.BHATTACHARIA: I would like to ask Father Holland a
13 question. What would you suggest, Father, being
14 associated with the youth problems in St. John's, this
15 drop in centre. What personnel would you suggest there
16 and whose responsibility is it to get this thing going?
17 FATHER HOLLAND: Let me take the second
18 question first, because it is an easy one to answer.
19 Whose responsibility is it? It is our responsibility.
20 It is so easy to shift it to politicians and it is not
21 a political question. It is a question of money, I
22 understand. But even if we had the money, would it be
23 a viable drop in centre? It is our responsibility.
24 Number two, who should run it? It should of course be
25 run by the teenagers themselves, and I think any other
26 approach is a false approach to it. They would never
27 go to it. I could sit at the entrance with my little
28 guest book, 45 years of age,and I shall see very precious
29 few people who would come into that drop in centre. It
30 has to be run by them and it has to be staffed by them.

It may be guided by others but they are the only ones. The ones who are helping the teenagers now, I can inform the doctors of this, if you get on a bad trip you don't go to the doctor, you have one of your fellow teenagers help you down. That is the facts. That is the facts. And the doctors spoke this morning about the number of bad trips that they had treated, and I think they could get some teenagers here who have treated a lot more bad trips than the doctors, and they know it.

DR. BHATTACHARIA: I fully agree with you.

DR. LEHMANN: Then apparently the teenagers are quite expert at it, so I should like to ask Dr. Pottle who is still with us --- I understand he would represent the Department of Health. What would the Government's position or attitude be towards the drop in centre, the official attitude. Would there be any sympathy, would there be financial support expected or have representations been made in this regard?

DR. POTTLE: I have been here all morning and you have not heard from me at all, except for a few nods of my head. Not because I am disinterested but because I am interested indeed. But I welcome frankly the very few opportunities of this sort to listen to other people. We talk as adults and professionals, and we fool ourselves quite a lot and this is an occasion where we can sit down and listen to other people. I would like to just make one or two points,Mr. Chairman, and I will get around to Dr. Lehmann's question while I

1 am on my feet now. There is nothing very scientific
2 I want to say, but in my travelling around Newfoundland
3 I get the very distinct impression in the past four to
4 six months that the use of substances or chemicals such
5 as speed is probably among the top ones right at the
6 moment, LSD and the simpler ones are down at the bottom.
7 This is a little contradictory in terms of the
8 questionnaire which was sent out to the doctors, and I
9 think probably it is understandable. I am just under-
10 lining what Father Holland and the boys are saying.
11 Now the second thing is being a consultant to the
12 governmental agencies. It puts me in a rather awkward
13 position because I don't want anybody to get the
14 impression that I am talking on behalf of a Government
15 service, and having a consulting role to fulfill. I am
16 sure that we recognize the fact that there is some
17 limitations to what I can say. But this I can say, that
18 I know that the people in the Department of Health and
19 people in other Departments are extremely interested in
20 receiving ideas and suggestions as to programmes which
21 can be established in the communites and in what one
22 might call viable alternatives to drug usage. And some
23 of us today are somewhat disappointed that we have not
24 been getting more concrete suggestions from the community
25 level. If I might say, just a few days ago I had the
26 pleasure of sitting on a committee, an inter-agency
27 committee in a small town in Newfoundland, and there
28 were quite a lot of young people on this committee, and
29 there were a few things they were saying that interested
30 me very much, and I think would interest anybody very

much and that is, they are talking in terms of how they can be involved in planning activities within the school structure and the structures that they now have. And they are talking about trying to do these things themselves. I heard one group of people talk about a drop in centre and they said, "Fine, what would this drop in centre be for? Would this just take care of people who have drug problems, and if so, what happens to all the rest? Do we have to isolate this from other community services? If so, would this tend to focus the problem even more sharply, and make this a drug centre kind of operation?" Or is it the kind of thing like problems in living which they were familiar with in talking about, the various kinds of problems in living for which they must have some structures and facilities within the community and which they would like to help to construct themselves? Now this is the kind of thing they are talking about.

One young man for instance brought up the question that maybe we should be careful about building services which would further isolate problems and worry about people walking in the store. And I am going to walk in this one, but they were fairly cognizant of the fact that a lot of young people do go into a building and when they get into severe difficulty they need to know that there are particular kinds of resources available. Now to get back to your question again, I have good reason to believe the people in authority have their ear close to the ground and get the most receptive people in the communities if youth would

1 start spelling out some of the things that they feel are
2 necessary.
3 DR. LEHMANN: Thank you, Dr. Pottle.
4 MR. CAMPBELL: I forgot your name, but I
5 would like to get back to this: one thing that wasn't
6 mentioned in the questionnaire was alcohol. How wide-
7 spread is alcohol use in your opinion?
8 MR. HENLEY: I would say alcohol use is
9 as widespread as the teenager would like it to be.
10 Teenagers today in St. John's no matter what age can be
11 served in a retail store, or the Liquor Commission store.
12 So the teenager would want to have alcohol, any certain
13 alcohol, he could have it without any problem. Whereas
14 let's say in other communities where they would have to
15 go through a few channels to get hold of alcohol. And
16 also teenagers today don't use alcohol because drugs
17 are much cheaper. Few can spend approximately $6.00 for
18 a bottle of good whiskey or gin and you get a good hit
19 of, say, acid for $3.00. What would you take? Getting
20 back to the economic status, it is cheaper.
21 A lot of teenagers today --- I remember
22 you could say a few years ago alcohol was the thing.
23 A lot of teenagers today would get together in groups
24 and maybe drink socially, but then again a few years
25 ago teenagers would drink to get drunk, to be in that
26 state of mind of drunkeness, that is all. Today the
27 teenager wants to get in a state of mind where he
28 doesn't know what he is doing, and he would do it on
29 something more than alcohol, something greater than
30 alcohol, and it would have a more widespread effect than

alcohol.

DR. LEHMANN: Greater than alcohol?

MR. HENLEY: I would say greater than alcohol.

DR. LEHMANN: What do you mean by greater?

MR. HENLEY: Say the psychedelic effect of a trip where the teenager's perception in colours, in forms, in objects, everything is completely distorted. It is left up to the imagination to decide upon. But when you are in a drunken state, you just don't know what you are doing, but when you are in a state --- when you are, say, stunned, and you know what you are doing and do what you want to, and you could like what you are doing. So I think the teenagers today accept drugs rather than alcohol because --- that is to say, accept it if they want to go to an extreme, but if they want to just be sociable and maybe a few fellows might get together after a hockey game and have a drink. That is accepted, you know, for teenagers today. But rather they don't any more drink to get drunk and that is about it.

THE CHAIRMAN: What is the attitude of teenagers towards religion in the church?

MR. HENLEY: Today in the church, teenagers are beginning to accept it again, because the church is modifying to the needs of teenagers and a lot of societies. Like just recently in the parish I am in teenagers have their own mass now. They run the whole show themselves, and they have the responsibility of the whole thing and they really like it because it is their thing, and they

1 are doing what they want to do.

2 But when you take, when I was in the

3 earlier grades you get the catechism, who made the world:

4 God made the world. You know, that was the thing with

5 teenagers then.

6 Well now religion is a widespread learning

7 of all of the morality of the world, the moral standards

8 of the world in religion today is important. Like

9 Father Holland mentioned --- I was in that class he

10 asked when he asked "How would you like to study religion

11 this year?" and it ranged from communal homes to racialism;

12 to drugs; right down to acceptance in society. It is

13 all basically religion, but then again it doesn't have

14 that brand of the church on it, which most people, when

15 they hear "religion," they just say, "That is religion",

16 but if people realize what religion entails it would be

17 better. But teenagers today do realize that, because in

18 religion classes it is sort of like the complete debate

19 where everyone can express their views. There are no

20 notes like you see in a history class, or before history

21 classes. You write an exam and you write what you want

22 to write as long as you have statements or examples to

23 back what you write. And say if one problem is put up

24 to me, if I completely disagreed with it, and even it is

25 against the moral code, if I have good enough backing,

26 good enough examples and reasons for why I did that, I

27 would be --- I would get just as good a mark, would be

28 accepted just as well as the teenager who would accept

29 it and who would have other examples. It depends on

30 the individuality of the teenager and the teenager's

intellectual ability.

MR. CAMPBELL: Do you think that applies to Protestants as well as Catholics?

MR. HENLEY: I would say so, yes.

MR. CAMPBELL: And you move in a circle of Protestants as well as Catholics?

MR. HENLEY: Yes.

MR. CAMPBELL: You say you are talking about 15, 16 and 17 year old population?

MR.HENLEY: Yes.

MR. CAMPBELL: Would most of these views run into the 18, 19 and 20 year old population as well?

MR. HENLEY: I would say they would, because it depends upon how long a teenager or this method of teaching --- a lot of things a teenager believes in depends on their educational system and how they are taught, and what standards are set up in their schools. Like you just mentioned about does it apply to Protestants as well. Most Protestants in --- most schools in St. John's are not denominational, but the school I go to is Conzaga which is run by the Jesuits which is a Catholic order, but then again a lot of Protestants go to that school; a lot of Hindus go to that school. And today I think that 19 and 20 year olds are beginning to have that same outlook, but it is greater in the teenagers who are just in high school who have just been subjected to that type of education. It is only in the past few years this type of information has been provided by us where we could think on our own rather than learn what other people think. We develop

ourselves now rather than developing thoughts of others. And in that bracket, say, 18 to 20, teenagers are just beginning to do that, and they weren't doing it, and it depends mostly upon whether they are working or if they are still in the educational system of, say, university or even high school.

MISS BERTRAND: I wonder if we could hear from the last group in this room? Would you have something to contribute to discussion?

THE PUBLIC: Well, I have a report here from my son, he wrote last night, and he is 17, and I became interested in the drug problem and I heard they were to discuss it and I asked if he would give me his views on the drug problem in St. John's, and in particular at the school at which he attends, and he wrote out a two page report, and maybe if you would like to hear this, I think one or two paragraphs are very worthy, and the Commission might be interested in them. He heads it up, "The Non-Medical Use of Drugs" and he goes on to explain the drugs that are used in the St. John's and the price. I don't know if this is of interest or not. Maybe I could drop that part of it, or maybe would you like to hear it?

THE CHAIRMAN: Would you leave that report with us?

THE PUBLIC: Yes, you could have it.

He said, "Drugs commonly found and used by St.John's youth.

Name: Hashish, marijuana, LSD.

Common name: Hash, grass, acid,

mescaline (peyote), common name: mesk.
Prices of drugs to St. John's youth.
Hashish, a nickel, which is $5.00; a dime, $10.00; ounce, $30.00.
Marijuana, nickel bag, $5.00; dime bag, $10.00; ounce $30.00.
LSD: usually sold by the tab, tablet about the size and form of a children's aspirin, for $5.00 or $6.00 depending on the pusher. In times of over supply or fear of police may be acquired at $3.00 or $3.50. LSD can be obtained in Toronto or Montreal for as little as 50¢ to $1.50. The reason for the difference in cost is the number of times it changes hands before it reaches St. John's. Everyone must make a profit, so there goes your profit motive.
Mescaline: also sold by the tab usually cost 50¢, more than the price of LSD at that time. LSD, $3.50, Mescaline, $4.00, etc.
Within this city there is also a ready supply of heroin, morphine and opium for those who wish to try these drugs. Thankfully, however, they are not as easily attainable as marijuana, hashish, LSD and mescaline. You need only want to try either of these four and tell the right person or spread the word around

1 and within an hour of the time you open
2 your mouth you may be confronted by a
3 pusher. If this fails, you need only go
4 to any high school, university or place
5 where young people gather and easily obtain
6 hashish, marijuana, LSD or mescaline.
7 Young people now in junior high schools,
8 grades 7, 8 and 9 with the right connec-
9 tions may now obtain these drugs, and from
10 my own knowledge of high school life, I
11 would say 25% if not more have tried at
12 least one of the mentioned drugs. This
13 number increases weekly."
14 That seems to point out what has already been said here
15 this evening.
16 "Alcohol has always been a problem in high
17 schools, although probably unrecognized
18 by many. In fact every weekend groups of
19 teenagers hold get togethers (parties)
20 with the express purpose of getting drunk.
21 Alcohol is really no problem to get even if
22 one is underage."
23 And this confirms what a teenager just said across the
24 way, that there is no problem really to get alcohol.
25 And this is my son's own personal view. He said,
26 "If drug users realized the seriousness
27 of what they are doing. The fact that
28 drugs are illegal and they may be spoiling
29 their future, then I think it is their
30 choice, their business, and their decision.

1 To try to put down one curiosity, maybe
2 once, all right, but to continue is a
3 choice."
4 So this is what he wrote last night and I think what we
5 need is more communication between parents and children
6 and I think my wife was shocked when she heard that he
7 was going to experiment with marijuana and right away
8 she saw red. But I think if you have a dialogue with
9 your children and you can sit down and talk about the
10 problem and give your views, but also listen to what they
11 have to say, I think what has been said about teenagers
12 across the way here is that we are tending to see things
13 from our own point of view, and we insist that they
14 follow in our own footsteps and we do not give them
15 enough credit for having an opinion of their own, and
16 consequently we do not have any communication with our
17 children, and if we could improve the communication with
18 our own children and they could be informed on the
19 harmful effects of drugs through education and through
20 helping them along, I think that we can overcome the
21 problem. Thank you.
22 THE CHAIRMAN: Thank you. Could you leave
23 it with us?
24 THE PUBLIC: Yes.
25 MISS BERTRAND: No other voices from ---
26 DR. LEHMANN: You did not debate it with
27 your son?
28 THE PUBLIC: Yes, we had several talks.
29 He was in a group of boys, about fourteen in a group, and
30 they used to get together, they all tried it and he tried

it once and that is it with him, he realized afterwards that it was not the thing for him, and he finally found a girl friend and got interested with her, and broke off from the group.

DR. LEHMANN: Another addiction?

THE PUBLIC: Yes, right, which was a good one, I would say.

DR. LEHMANN: You approve of that more than of marijuana? Did you let him know that?

THE PUBLIC: Yes.

DR. LEHMANN: You did let him know that?

THE PUBLIC: Yes.

FATHER HOLLAND: On the question of teenage alcohol in St. John's, it is much larger than I think anyone really realizes. Alcohol is very, very readily available. It can be obtained just about any place and easily obtained. And we don't have any problem with alcohol in Newfoundland. Figures back us up on this, we consume great quantities of Blue Star and I think we are probably one of the largest consumers across the country, and we have accepted alcohol as a way of life. We have even got our own brew. We are all proud of it. I have never dared take it, but I would recommend it to the Commission. It may be their last hearing.

MR. CAMPBELL: Where do you get it?

THE PUBLIC: In the hotel barroom.

FATHER HOLLAND: But alcohol we have. And I would like to mention a point that was brought up and not emphasized that is the fact that we do not

have a transient population in Newfoundland, so what we speak about we speak about as an enclave, as ourselves. The figures you get in Montreal, or if you go to Toronto, you have got some Newfoundlanders there and you have some from Saskatoon, but here we represent ourselves in these figures. So they may sound alarming to us but possibly they are not as bad to you. They are to us.

THE CHAIRMAN: I wonder if there is any response to Dr. Pottle's remark about speed. Dr. Pottle said he noticed in recent months, he had formed the impression in his travels around in the recent months, the last six months, as I recall, an increase in the use of chemicals and referred to speed, amphetamines, also LSD, and I understood him to say it was his impression that this increased use of chemicals, amphetamines, was relatively more important than the increased use of cannabis. Was there any response to that?

FATHER HOLLAND: I could respond on two levels. Last year we got dried up on marijuana and just everyone was dropping acid, was the experience we were having. This year speed seems to be the favourite drug. A shipment comes in not infrequently and when a shipment comes in there is one hospital that is warned that they are going to have a bad weekend. We are in a bad spot too, we have no place to go to check out whether it is good or bad material unfortunately. I believe the Commission has asked for labs throughout the country, and this is one of the areas where we could certainly use this.

DR. LEHMANN: In this connection, even without having analysis it is quite unfortunate that if somebody has decided to shoot speed, that he at least sterilizes the needles. How much of this is being adhered to here? This comes long before analysis. You might know about this. Do people shoot speed recklessly here and therefore get infections and badly chopped up veins, and hepatitis, or are they careful about it?

MR. HENLEY: It was reported in the General Hospital about four months ago or something that a family of --- there was one person who came back from Toronto, himself and his two sisters and his three brothers all came in with an unsterilized needle and they all used that same needle. Also reports of a lot of high school students have been in the hospital and who have had to have such operations that an unsterilized needle caused. There was a lot of recklessness here because students, and I say teenagers, don't know what they are tempering with.

DR. LEHMANN: They don't, or they don't care?

MR. HENLEY: They do know what they are tampering with in the sense that they know it is speed and they know what it can do to them, but they don't know how to use it.

DR. LEHMANN: Why are they not being taught?

MR. HENLEY: I don't think our educational system today will accept the teaching of how to shoot speed.

1 DR. LEHMANN: Well from one teenager to
2 another. You know about it and a lot of your friends
3 probably.
4 MR. HENLEY: I don't know about it. I know
5 of it. I wouldn't have the guts to try speed.
6 DR. LEHMANN: You don't know enough to
7 tell somebody ---
8 MR. HENLEY: I could warn them on the
9 dangers of doing that, but that's as far as it goes.
10 I wouldn't be able to show them.
11 DR. LEHMANN: Everybody knows that if
12 you hold it over a candle, it is in a way sterilizing
13 the needle. Doesn't everybody know that?
14 MR.HENLEY: Well he sterilizes the needle.
15 I would say that everybody wouldn't do that at the
16 certain time, because when they get it in that needle,
17 they don't care what is in front of them, that certain
18 time between when it is there and when it has to go in,
19 they are just in a world where they don't ---
20 DR. LEHMANN: So they would not care, even
21 if there was an analysis and they knew it was very bad
22 stuff they were getting, they would not care what they
23 were shooting?
24 MR. HENLEY: I wouldn't say so, no, because
25 a lot of the teenagers know what is coming in here, it
26 is being cut down and then broken up by the hands it is
27 going through. But there is nothing else to get here.
28 That is the way it is.
29 DR. LEHMANN: I don't understand this.
30 Perhaps I didn't understand you right. You said that if

they would know through certain analysis that a shipment was bad stuff, they would not shoot it. At the same time you say that if they have the stuff they would not take a minute or thirty seconds for sterilization because they must get it in right away. So anyway, you say they would be very careful and not take anything that they are told is not good and on the other hand, you say they don't care.

MR. HENLEY: If you take a starving man and you give him either an old crust of bread which has been in the garbage can for a certain length of time, he doesn't care how bad it is as long as it has come along. Well that would mean that it would take any sort of stuff, bad stuff, and it is something else available, if it was better stuff, they wouldn't. But a lot of the stuff that comes into St. John's is not good and there is nothing available, so they will have to take it to a lesser degree.

DR. LEHMANN: Would they have to check it out and say "I don't want the green capsule, I will wait half an hour and get the blue one," but they would not wait thirty seconds to sterilize the needle?

MR. HENLEY: I would not say so, no.

DR. BHATTACHARIA: I know two students in St. John's and they are taking speed or LSD and I do not think it is a trend, it just happens to be his drug, and if you ask about two months ago, I have asked one of these pushers and he has said there is no speed, "we could not get it." Some time ago they were taking marijuana. If you took it today you find an amphetamine.

1 DR. LEHMANN: Yes I know. I was just
2 interested in this particular area, that appears to me
3 the inconsistency of taking care to get good stuff but
4 not taking care of how to administer it.
5 DR. BHATTACHARIA: I suppose one has to
6 consider the situation in which they are taking it.
7 They have to hide. They would be doing it in a car,
8 in a park, and the man who was giving it very seldom,
9 I don't think --- the first step with injections is
10 always given by someone else, and if the giver says "well,
11 that is okay," and you know if you exchange candy from
12 one mouth to another, or a cigarette from one mouth to
13 another, infectious hepatitis under these conditions,
14 the kids do not understand it and the infectious
15 hepatitis is being spread through blood transfusion in
16 the hospitals. Even the medical profession failed too.
17 I think to ask the kids to be well aware of it, I think,
18 is asking too much.
19 DR. LEHMANN: No, but I think what you
20 said about having to do it in hiding is very relevant
21 because there are cases of lockjaw developing because the
22 kids thought that they had to hide the needle and all
23 the works in the ground, in a hole in the ground and
24 then they dug it up in the park and injected themselves
25 and this is done as well. Now at least they should
26 spread the warning of this by other teenagers, and
27 completely simple --- I think it would be at least as
28 important as making sure that simple analysis would
29 provide information about the nature of it.
30 MR. HENLEY: Could I ask you a question

about analysis? How would a teenager find out? Who is the lab man, where is the --- so if he was to go to a lab and it would be confiscated, he can't go in there and ask them,is this good or is this not good, and I do not think it will be accepted where there is a little check out where you can find out if what you are doing is up to par, or if it is not.

DR. LEHMANN: You know the little check out would cost about $45.00, so it is not just going to the next pharmacist and asking him to do a favour which he does not want to do. It is a big business to set it up in a university or a laboratory. So it is not just a little thing.

MR. HENLEY: I realize that and I also realize that of helping anyone to do such a thing.

DR. LEHMANN: But there have been many recommendations made that this should be provided, a chemical check.

DR. BHATTACHARIA: How would you do that without legal implications? Obviously you have to make a legal position on this. You have to legalize it. And as long as it is a black market as I have mentioned in the God Father, that book is also about the black market, you could not possibly have anything at all.

THE CHAIRMAN: Why?

DR. BHATTACHARIA: As the man said, if I was to take a needle or if I am going to take it, I cannot go to a druggist or chemist to analyze the drug and then I don't get the drug, and if you hear the price of it, then the second tablet,you take it. And again your

report on the drug scene in Canada shows how much mixture there is. Marijuana has a lot of atropine, but if I am going to take marijuana, I am not going to go and get it analyzed.

THE CHAIRMAN: What is to prevent the agency from being authorized to obtain specimens on the street? This kind of analysis has been operated.

DR. BHATTACHARIA: But then you have to prosecute the chap at the same time.

THE CHAIRMAN: No, they don't have to. They may be authorized for purposes of analysis to obtain samples; not required to prosecute.

DR. BHATTACHARIA: Who would take the drug? Would they take the drugs? I only push when you are going to take the samples from me. Who is going to do that? What agency would get involved?

THE CHAIRMAN: Presumably you would have a lab with people who could obtain these samples.

DR. BHATTACHARIA: Who would you go to there?

THE CHAIRMAN: You know it has operated. I mean the Addiction Research Foundation has been running such a lab in Toronto.

DR. BHATTACHARIA: It is only where you have a Foundation, but in Newfoundland there is nothing.

DR. LEHMANN: And it could be set up. The Government has not decided to do so yet. It is felt that it could be possible. Whether it is feasible technically and whether they will decide, that is another question. But in the meantime, one thing can be done to

ensure the safety, and that is for the teenagers themselves at least to know what they are doing within their own means of control.

DR. BHATTACHARIA: I have also seen, and this was in England, that you got supposed LSD reaction or something like that and you took the sample they had in their pocket and it is just pure and simple sugar; there is no LSD at all in it. So they are just sort of reacting in a fashion so it looks like they had LSD, so some of the reactions we have observed are not entirely due to the drug; some of the reactions I am very sure are due to the panic situation the kid gets into. I have seen a chap who has just had a marijuana and went into a coffee house, started to have a cup of coffee and people who are looking at him, and it panicked him. And obviously whatever he did, this panic reaction was branded to be the marijuana. All you needed to do was talk to the guy and say, "Well, nobody was really going to arrest you," and he would come down.

THE CHAIRMAN: Well, I guess we should call it a day. It is now the hour of 5:00 and we set the hour of 5:00 for adjournment, and we have had a very full day here and you have been very helpful, and I would like to on behalf of the Commission thank everyone present for their assistance today, attention and assistance. We have received a great deal of assistance and we are glad to come back here a second time. It probably will be the last time before the final report. We would be very grateful if you would send down any views that you think would help us, any new developments

and information to our office at 100 Metcalfe Street in Ottawa, sent to the Drug Inquiry Commission, and keep us in contact with the situation if it is developing. It would be of great help to us. That is one of our problems, to remain in contact with the scene across Canada.

Thank you very much.

---Upon adjourning at 5:04 p.m.